REPORT OF THE

NOVA SCOTIA LEGISLATIVE SELECT COMMITTEE ON HEALTH

PROVINCE OF
NOVA SCOTIA

VOLUME ONE

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Report of the
Nova Scotia Legislative
Select Committee
on Health

Volume I

Hon. Arthur R. Donahoe, Q.C.
Speaker of the
House of Assembly
12th Floor, Toronto
Dominion Bank Building
1791 Barrington Street
Halifax, Nova Scotia
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Dear Mr. Speaker:

I am writing in my capacity as Chairman of the Select Committee on Health to inform you that the Committee has completed the first stage of its inquiry into the adequacy and delivery of health care in Nova Scotia.

In accordance with Resolution No. 192 passed by the House of Assembly on April 15, 1982, and re-established by Resolutions No. 222 on May 27, 1983, and No. 112 on May 28, 1984, I am pleased to submit to you Volume I of the Report of the Select Committee on Health.

Respectfully yours,

R. Colin D. Stewart

R. Colin D. Stewart, M.L.A.
Chairman
Select Committee on Health

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Executive Summary

Volume I of the Report of the Nova Scotia Legislative Select Committee on Health addresses some of the most important issues and concerns facing Nova Scotia's health care system. The Report includes chapters on health care financing, prevention, hospitals, home care, and medicare/hospital insurance. The Report contains forty-two (42) recommendations on these topics for consideration by Government.

After reviewing health care financing the Committee concluded that as a percentage of total provincial government expenditures, Nova Scotia's expenditures for health services have been remarkably stable over the past twenty years. Compared to other provinces, this same measure shows that Nova Scotia's emphasis on health care has been strong, placing fourth on average among the provinces. However, in recent years provincial revenues have not kept pace with health expenditures. In particular, federal transfers for health services have lagged behind increases in health expenditures. Hence the Select Committee recommends that the Federal Government be encouraged to provide appropriate funding to help Nova Scotia cover the costs of additional required health services.

The Committee noted that prevention - defined as programs and services which avert the occurrence of disease, illness or dysfunction and which promote the optimal health of the population - has long been recognized as a major theme in health care. However, emphasis in the health care system has been placed on curative medicine and treatment. Based on its investigations, including evidence from recent medical studies, the Select Committee concluded that the health of Nova Scotians can be improved, and significant savings in health care expenditures can be obtained through preventive programs. The Committee therefore urges government to give prevention a high priority and recommends that a Committee be established to devise a preventive health strategy for the Province. The Committee also makes specific recommendations regarding preventive action in areas such as health education, prenatal care, discouragement of the use of tobacco, alcohol and drug abuse, seat belt legislation, and drunken driving.

Nova Scotia's hospitals are a key component of the health care system in the Province accounting for over two thirds of current operating expenditures on health. The Select Committee concluded that a very high standard of care is provided in Nova Scotia's hospitals, but felt that improvements could be made to the hospital system. Recommendations pertaining to hospitals were made by the Select Committee in the following areas: capital funding for hospitals; target ratios for the provision of acute and extended care beds; the geographic distribution of hospital beds; policy changes to promote flexibility and innovation in hospitals; and the promotion of regional cooperation in the operation of hospitals in Nova Scotia.

More recommendations were made to the Select Committee regarding the development of a home care program in Nova Scotia than for any other specific type of program. One of the most important reasons for this interest is that institutional health care is relatively expensive. By contrast, a co-ordinated home care program involving health and social services personnel and other agencies represents significant savings while continuing to ensure high quality care for the patient. The Committee therefore urges the government to implement a comprehensive, co-ordinated, home care program for Nova Scotia. As a first step, an advisory committee of health and social services professionals should be established to identify specific public needs and to advise the government on planning a co-ordinated program.

The Select Committee's investigations into certain aspects of Nova Scotia's Health Insurance System were to some extent overtaken by the passage of the Canada Health Act, which became law on April 7, 1984. Nonetheless, the widespread concern voiced by Nova Scotians regarding direct charges (user fees, premiums and extra billing) prompted the Committee to address the subject in this Report. After reviewing the effects of direct charges in other provinces the Select Committee recommends that user fees should not be introduced in this Province, and that Nova Scotia legislation with respect to extra billing by physicians be amended to comply with the Canada Health Act. If additional provincial revenues are required to finance health care in Nova Scotia, progressive taxation instruments should be used instead of health care premiums. Many recommendations were made to the Select Committee concerning the extension of benefits under the Health Services and Insurance Act to include additional services and supplies. The Committee recommends that, subject to the availability of funding, benefits should be extended to include a number of additional areas which are specified in the last chapter.

I Introduction

Terms of Reference

On April 6, 1982 notice was given that a Select Committee on Health would be established "to inquire into the adequacy and delivery of health care in the Province and all matters pertaining to health care facilities, and to consider and to report to this House the observations, opinions and recommendations of the Members of the Select Committee respecting any matter relating to the adequacy and the delivery of health care in the Province and health care facilities."

The Committee was struck on April 15, 1982 by a Resolution of the House of Assembly (No. 192), and re-established by Resolutions No. 222 on May 27, 1983 and No. 112 on May 28, 1984. These Resolutions are included as Appendix II.

The Members of the Select Committee on Health were: Dr. R. Colin D. Stewart, M.L.A. (Chairman); Honourable Gerald Sheehy, D.V.M., Minister of Health; Honourable Edmund Morris, Minister of Social Services; Honourable Laird Stirling, Minister of Consumer Affairs; Honourable John Leefe, Minister of Fisheries; Honourable Arthur Donahoe, Q.C. (ex officio), Speaker of the House of Assembly; Mr. Greg MacIsaac, M.L.A.; Mrs. Alexa McDonough, M.L.A., Leader of the New Democratic Party; Mr. A.M. (Sandy) Cameron, M.L.A., Leader of the Opposition; Mr. Vincent MacLean, M.L.A.; Mr. Fraser Mooney, M.L.A.; and Dr. J. William Gillis, M.L.A.

On November 16, 1983, a Steering Committee consisting of Dr. Stewart (Chairman), Dr. Sheehy, Mrs. McDonough and Mr. MacLean was formed to coordinate the writing of the Select Committee's Report.

The staff for the Select Committee on Health were either seconded on a part-time basis from Government Departments, or engaged on a part-time contractual arrangement. Mrs. Lois Smith acted as Secretary to the Select Committee, Mr. Wayne Doggett was the Research Advisor, and Mr. Wayne Edgar was Research Assistant.

Approach and Methodology

The Terms of Reference as stated above were obviously broad in scope, encompassing virtually the whole spectrum of health care in Nova Scotia. To focus its work the Select Committee on Health interpreted its mandate in several ways.

First, the Select Committee on Health wanted to ensure that every Nova Scotian wishing to express opinions, and make recommendations regarding health care in Nova Scotia would have the opportunity to do so; and that these views, once expressed, would be freely available to the public. The Select Committee on Health felt very strongly that the provision of a forum for public expression of viewpoints, ideas, and the stimulation of debate on health care issues was an important part of its task.

The Select Committee on Health met for the first time on June 9, 1982 to organize a series of public meetings across the Province. In preparation for its work the Select Committee received briefings from officials in the Department of Health early in September, and the first of a series of advertisements requesting submissions to the Committee from interested persons appeared in newspapers in October, 1982.

The Select Committee on Health began public hearings on November 23, 1982 in Halifax, and subsequently conducted hearings in Sydney, Yarmouth, Kentville, Antigonish and Truro. The exact dates and places of the nineteen (19) hearings are listed in Appendix III. By the time the public hearings were concluded in Halifax on November 16, 1983, one hundred and fourteen (114) groups and individuals had appeared before the Select Committee to present their submissions, and to engage in discussion with Members of the Committee. An additional seventeen (17) submissions were received in the mail. The one hundred and thirty-one (131) submissions comprised two thousand and twenty-six (2,026) pages, and contained approximately six hundred and eighty-two (682) recommendations.

These submissions were made by concerned Nova Scotians from all walks of life, including health professionals, voluntary health agencies, religious organizations, and ordinary citizens. The submissions reflected the broad scope of the Terms of Reference of the Select Committee, touching on a wide variety of health care issues. These included prevention, provision of various programs such as home care, recommendations regarding health education, concerns regarding Medicare and user fees, involvement of consumers and health workers in formulating health policy, environmental concerns, hospital administration/services/construction, occupational health and safety, perinatal, prenatal and childbirth concerns, training and manpower requirements of health professionals, psychiatric and mental health concerns, structuring of the health care delivery system, abortion, and many other health care concerns.

Overall, the majority of submissions made to the Select Committee on Health were articulate, extensive, and reflected Nova Scotians' ongoing commitment to, and concern for, their health care system. The actual submissions, and the discussions that took place at public hearings are now a matter of public record. The submissions made by the public are available at the Public Archives of Nova Scotia, along with the verbatim Hansard transcripts of both the presentations, and the questions and discussions that followed the presentations. **The Select Committee's task to solicit the views of Nova Scotians regarding their health care system and to make these views and opinions available has thus been fulfilled.**

The **second** major task arising from the Terms of Reference of the Select Committee on Health was to scrutinize the submissions made to the Committee, and submit a Report to the House containing the Committee's comments, observations and recommendations on health care in Nova Scotia. This part of the Select Committee's mandate will be addressed in two Volumes. This part of the Report - Volume I - addresses many of the important health care concerns considered by the Select Committee on Health, and Volume II will deal with those issues which remain to be covered.

To facilitate this task, the large volume of material to be reviewed by the Committee was reduced to manageable proportions in three steps. The text and recommendations in the submissions made to the Select Committee were summarized from 2,026 pages to 232 pages; the recommendations contained in these summaries were then listed separately; finally, the recommendations in this list were grouped into selected topics as shown in Appendix I, "Summary of Recommendations by Selected Topic".

The recommendations listed in Appendix I were in many instances repeated by several groups or individuals. Consequently, these recommendations have been shortened, and in some instances reworded, although every effort was made to retain the original intent of the recommendations. An abbreviated title of the groups or individuals who made each recommendation appears after the recommendations listed in the Appendix.

For example, in Appendix I, recommendation 1.1 "Raise the priority of and expand health promotion and preventive medicine services in a community setting", was made (in one form or another) by seven different groups. Hence this recommendation is followed by seven abbreviations - PHANS, VON, St.J.A., NSFL, HC/NDP, Zonta, WHEN - to indicate who made this recommendation. In terms of counting, this recommendation comprises seven (7) of the total of six hundred and eighty-two (682) recommendations.

The grouping of recommendations under selected topics was to some extent arbitrary. Consequently, there are some overlaps between topics, and instances where recommendations could have just as easily been listed under one topic as another. For example, recommendation 10.7, "Provide funds for nutritional education materials and counselling during pregnancy", is a preventive health measure, and could have been listed under prevention. However, it was felt that the specific focus of the prenatal, perinatal, postnatal topic was a more useful categorization for purposes of reviewing the recommendations. This type of decision had to be made many times in compiling Appendix I.

The organization of the recommendations made to the Select Committee, as outlined above, permitted a systematic review of the material. The emphasis given to certain topics by Nova Scotians, as reflected in the number of groups who addressed various topics and in the number of recommendations made under each topic, were not the only criteria used by the Committee to establish priorities. However, in conjunction with work by the Committee's research staff, comments volunteered by knowledgeable persons in the health professions, information provided by the Department of Health, and the experience in the health care field by members of the Select Committee itself, they were useful guideposts used in structuring this Report.

The nature of the recommendations made by the Select Committee on Health in this Report varies from general to specific. This reflects the power of a Select Committee of the Legislature, and the resources at its command. A Select Committee cannot make laws or effect change per se; a Select Committee can make recommendations to the Legislature, and it is then the responsibility of the Legislature to decide upon the validity of these recommendations.

It should be noted that this Committee was not made up of technical experts. It was a Committee of Legislators set up to gather viewpoints and information, and report back to the House. The Committee did obtain expert advice in some areas, but it did not commission special studies, and to date has not travelled to other jurisdictions. Wherever possible, within the time frame and resources at its disposal, the Committee has made specific recommendations; in other instances the Committee has recommended that an appropriate task force, committee, or group be asked to investigate a specific topic, and recommend a course of action to resolve the problem.

In other areas, submissions contained recommendations that did not pertain directly to the Provincial Government or were related to other Government Special Committees or Task Forces. In these areas the Select Committee referred the issues to the appropriate body. For instance, a number of submissions dealing with various aspects of occupational health and safety were presented to the Select Committee.

This material was forwarded on December 9, 1983 to the Special Committee on Occupational Health and Safety, which had been established by the Provincial Government to examine this topic.

In summary, the Select Committee on Health addressed itself to the health care concerns of Nova Scotians to the best of its ability within the time frame and resources at its disposal. In fulfilling this part of its mandate the Committee strove to make recommendations that would improve the health care delivered to Nova Scotians, while at the same time remaining within the bounds of fiscal responsibility.

Design of the Report

As indicated above, the Select Committee on Health decided to divide its Report into two volumes. The decision to proceed in this manner was based on a number of factors. The sheer magnitude of the health care issues brought before the Select Committee dictated that a considerable period of time would be required to write the complete Report. However, as work on many of the important topics was concluded it was felt that this information should not be held back while the Committee's attention was focused on other, in many cases, unrelated health care issues.

A further concern was that the data and information used in writing certain sections of the Report does not have a long "shelf life". That is, information used to write the first sections of the Report could become outdated before the final sections are completed. In addition, the Committee felt that the material composing Volume I of the Report constituted a coherent package and the continuity of the Committee's work would be enhanced by submitting it at this time.

Volume I

The general approach taken by the Select Committee on Health in preparing this Report has been outlined above. Specifically, Volume I of the Report is made up of seven chapters which deal with some of the most important issues and concerns facing Nova Scotia's health care system today. After the introductory chapter, Chapter 2 contains an overview of submissions made to the Select Committee on Health. This overview was prepared using tables derived from Appendix I. The purpose of this Chapter is to catalogue, in summary form, the health care issues that Nova Scotians felt were important as reflected in several thousand pages of submissions.

Chapter 3 is concerned with health care financing. This chapter reviews health care expenditures, and revenues earmarked for health care in Nova Scotia, both currently and historically. Since any additional health service either requires new funds, or cancellation of an existing service to "free up" funds, this chapter in many ways sets the stage for the remainder of the Report.

Chapter 4 is entitled "Prevention". The theme of prevention in terms of programs and services that can avert the occurrence of disease and accidents, and which promote optimal health, is an important element of this Report. Chapter 4 not only addresses the concept and evidence regarding preventive programs, but also touches on a broad range of other topics raised in submissions to the Committee including nutrition, prenatal concerns, lifestyles, and information concerning specific diseases.

Chapter 5 deals with issues pertaining to hospitals. Directly or indirectly hospital expenditures account for more than two thirds of the "health care dollar", and constitute an essential part of Nova Scotia's health care system. Chapter 5 addresses issues such as capital funding for hospitals, appropriate bed ratios for the Province, the geographic distribution of beds, the need for flexibility and innovation in hospitals, and the importance of regional co-operation and planning.

One of the key conclusions of Volume I of the Report of the Select Committee on Health is that a comprehensive, co-ordinated home care program should be implemented in Nova Scotia. Chapter 6 examines the subject of home care, reviews the situation in other provinces, looks at services that should be provided in a home care program, addresses the question of cost effectiveness, and sets out a recommended course of action with regard to home care.

The final chapter of Volume I pertains to Medicare and Hospital Insurance concerns. During the deliberations of the Select Committee on Health there was a national debate that focused to a great degree on the issue of direct charges for health care. The Select Committee felt that it was important for Nova Scotians to know its views on this matter, consequently, most of Chapter 7 deals with that issue. The remainder of the Chapter concerns specific additions to the M.S.I. plan that the Select Committee felt, in principle, were worthy of inclusion as insured benefits.

Volume II

Although Volume I of the Select Committee on Health's Report addresses many of the important health care issues and concerns facing Nova Scotians, there are many important health care topics that are still being considered by the Select Committee on Health. These issues will be the subject of Volume II of the Committee's Report. Some of the issues that will be addressed in Volume II are outlined briefly below although the list is not necessarily all inclusive, nor in any particular order of priority. Three topics are discussed in some detail to give an idea of the form that Volume II will take, and the remaining topics are simply listed although they may be of equal importance.

The **education of health professionals** was the general subject of forty-five recommendations. A wide variety of specific topics such as manpower planning for health professionals; training needs in specific areas including learning disabilities, human sexuality, prevention, etc.; the organization and funding of various health professional schools and programs, mainly at Dalhousie University; and the rationalization of licensing of various allied health professionals. Obviously these topics are complex and will require careful consideration.

The topic of **mental health** was also the subject of a large number of recommendations (39). Recommendations under this topic were mainly concerned with programs and services for the mentally ill and for mental health in general. Recommendations concerning the extension and modification of existing programs included: making the Cape Breton Hospital accessible 24 hours a day, establishing a psycho-geriatric unit in the Cape Breton Hospital, improving services to families, providing emergency mental health treatment, improving services for young people, women and the elderly, providing psychiatric care in general hospitals, and providing respite care. New programs regarding effective case management, outreach and prevention were also suggested. A common theme running throughout the recommendations was the need to provide sufficient resources in the community to cope with the increasing number of patients discharged from hospital as a result of the movement towards de-institutionalization. The need for additional research in the area of mental health and some specific concerns of the mentally retarded were also brought before the Select Commiteee.

Many recommendations (36) were also made on the subject of "Health Education; Human Sexuality Education and Services". Many of these recommendations are related to the recommendations and discussion presented in Chapter 4, **Prevention**, of Volume I such as the recommendations concerning a school based smoking prevention program, and the provision of a sequential life sciences study program in the schools.

However, other issues such as the need for clinical programs and education programs dealing with human sexuality concerns, particularly birth control, the use of the media to promote health education, the subsidization of driver education programs in schools, and better co-ordination of health education among government departments are not addressed in Volume I.

The list of issues and concerns to be addressed in Volume II is long, and the subjects themselves are often complex and controversial. This list includes: specific women's health concerns; specific concerns of the elderly; the provision of community health services; expanded entry points for nurses and other health professionals; consumer and/or staff involvement in health policy; the environment; abortion; dental care; vision care including the appropriate role of vision care professions, and the subject of screening for vision problems; learning disabilities; and palliative care. Other issues such as prenatal, perinatal, and postnatal concerns, nutrition, some specific concerns of the disabled, and drug and pharmaceutical concerns have been dealt with to some degree in Volume I, but some aspects of these subjects could warrant further attention.

Finally, a significant number of recommendations urged that a more fundamental restructuring of the health care delivery system be undertaken than is reflected in the concerns addressed in Volume I. A number of briefs argued that a more integrated, comprehensive and long-range health care planning and delivery system is needed. This system would ensure effective integration of services and meaningful participation of people in health care planning decisions by providing for a regional planning process. (See also Volume I, page 57).

2 Overview of Public Submissions

How do Nova Scotians feel about their health care system? What kinds of concerns were raised in submissions to the Select Committee on Health? What kind of change was recommended to improve the health care system? These are the questions addressed, in a general way, in this Chapter of the Report.

The overall impression of the Select Committee on Health was that Nova Scotians are pleased with their health care system. This feeling was expressed by many of the groups and individuals who appeared before the Select Committee on Health as a preface to their detailed comments and recommendations.

However, the submissions also pointed out that there is room for improvement in our health care system. The submissions contained definite, and sometimes contradictory, views respecting ways the health care system could be changed to better meet the health care requirements of Nova Scotians. The following commentary and tables are based on Appendix I, "Summary of Recommendations by Selected Topic". This material illustrates the type, range, and emphasis of recommendations made to the Select Committee on Health regarding health care in Nova Scotia.

Areas of Concern

One measure of the importance given to various health care issues brought before the Select Committee is the number of groups or individuals who raised a particular topic in their submissions. This approach was taken in compiling Table 1 which shows the number of groups and/or individuals who made recommendations pertaining to the topics listed. Line one of the table reveals that thirty-seven (37) separate groups and/or individuals, composing 28.2% of the total of one hundred and thirty-one (131), made recommendations pertaining to prevention. More groups and individuals made recommendations on prevention than any other topic.

The topic entitled "Hospital: Administration; Construction; Services" had the second largest number with thirty-four (34) groups and/or individuals (26.0%) making recommendations in this area. This was followed by the topic dealing with medicare and hospital insurance issues which was the subject of recommendations made by thirty-one (31) groups and/or individuals. The only other topic which thirty (30) or more groups or individuals referred to in their recommendations was the education of health professionals; thirty (30) (22.9%) made recommendations in this topic. The fifth selected topic, consumer and/or staff involvement in health policy, was the subject of recommendations made by twenty-one (21) groups and/or individuals composing 16% of the total.

The first five topics are broad in scope, encompassing within them a variety of specific issues that are dealt with in other chapters. The sixth topic, home care, unlike the preceding five topics pertains to one specific type of program. Nineteen (19) groups and individuals composing 14.5% of the total made recommendations pertaining to a home care program, or components of such a program.

Table 1
***Number of Groups and/or Individuals who made Recommendations by Selected Topic**

Selected Topics	Number	Percentage of Total (131)
1. Prevention	37	28.2
2. Hospital: Administration; Construction; Services	34	26.0
3. Medicare and Hospital Insurance	31	23.7
4. Education of Health Professionals	30	22.9
5. Consumer and/or Staff Involvement in Health Policy	21	16.0
6. Home Care	19	14.5
7. Health Education; Human Sexuality Education and Services	15	11.5
8. Mental Health	15	11.5
9. Community Health Services; Expanded Entry Points	14	10.7
10. Prenatal, Perinatal and Postnatal Concerns	14	10.7
11. Environment	13	9.9
12. Specific Women's Health Concerns	11	8.4
13. Occupational Health and Safety	10	7.6
14. Abortion	10	7.6
15. Specific Concerns of the Elderly	10	7.6
16. Occupational Therapy, Physiotherapy and Rehabilitation	7	5.3
17. Drug and Pharmaceutical Concerns	6	4.6
18. Dental Care	5	3.8
19. Vision Care	5	3.8
20. Learning Disabilities	5	3.8
21. Palliative Care	4	3.1
22. Other (e.g. Nutrition, Municipal Health Boards, Disabled)	22	16.8

* This table presents the number of groups and/or individuals who made at least one recommendation concerning the topics listed. For example, under topic #1, thirty-seven of the groups and/or individuals made recommendation(s) concerning prevention. Note that one hundred and thirty-one groups (131) groups and/or individuals submitted briefs to the Select Committee.

There was a relatively even distribution of groups and individuals who made recommendations on topics from #7 through #15. These topics included health education, human sexuality education and services, mental health, community health services and expanded entry points, prenatal, perinatal and postnatal concerns, environmental concerns, specific women's health concerns, occupational health and safety issues, and specific concerns of the elderly. From 10 to 15 groups or individuals constituting from 7.6% to 11.5% of the total made recommendations in these areas.

Finally, from 4 to 7 groups composing 3.1% to 7.6% of the total made recommendations pertaining to occupational therapy, physiotherapy and rehabilitation, drug and pharmaceutical concerns, dental care, vision care, learning disabilities, and palliative care.

The last topic (#22) contains recommendations on a wide variety of health care subjects including nutrition, concerns of municipal health boards such as sewage disposal regulations, specific recommendations concerning the disabled, and a wide variety of other topics.

It should be noted that one group or individual may have made recommendations on one, or all, of the topics shown in Table 1. Hence the total does not equal 131, which is the number of groups or individuals who made submissions to the Select Committee.

Recommendations by Selected Topic

Another approach to providing an overview of recommendations made to the Select Committee is shown in Table 2. This table presents the number of recommendations made under each selected topic. Although the emphasis given the selected topics is somewhat different in Table 2, the ordering from Table 1 has been maintained to avoid confusion and facilitate comparision between the two measures.

An examination of Table 2 reveals that hospital concerns, medicare and hospital insurance issues, prevention, and education of health professionals received the largest number of recommendations. Over one-third (36.1%) of the recommendations made to the Select Committee focused on these topics. As shown in the table, 75 recommendations, composing 11% of the total of 682 recommendations, were related to hospitals; 72 recommendations (10.6%) of total recommendations concerned medicare and hospital insurance; 54 recommendations (7.9%) pertained specifically to prevention; and 45 recommendations (6.6%) concerned education of health professionals. These topics were also the top four in Table 1 although in a different order of importance.

Table 2 also shows the relatively equal weighting given a group of ten topics in terms of the numbers of recommendations made. This group ranges from mental health with 39 recommendations (5.7%), to occupational therapy, physiotherapy, and rehabilitation with 20 recommendations (2.9%). This group of recommendations composed 43.1% of total recommendations made to the Committee.

Excluding the "Other" category, the remaining seven topics accounted for 15.2% of recommendations. These topics ranged from community health services and expanded entry points, specific women's health concerns, occupational therapy, and physiotherapy and rehabilitation, all of which received 17 recommendations (2.5% of the total) to learning disabilities which received 9 recommendations. Thirty-eight recommendations (5.6%) of the total are listed under "Other". In this category, nutrition has the largest number of recommendations pertaining to a single topic (5 recommendations).

Table 2
*Number of Recommendations by Selected Topic

Selected Topics	Number	Percentage of Total
1. Prevention	54	7.9
2. Hospital: Administration; Construction; Services	75	11.0
3. Medicare and Hospital Insurance	72	10.6
4. Education of Health Professionals	45	6.6
5. Consumer and/or Staff Involvement in Health Policy	32	4.7
6. Home Care	29	4.3
7. Health Education; Human Sexuality Education and Services	36	5.3
8. Mental Health	39	5.7
9. Community Health Services; Expanded Entry Points	17	2.5
10. Prenatal, Perinatal and Postnatal Concerns	29	4.3
11. Environment	32	4.7
12. Specific Women's Health Concerns	24	3.5
13. Occupational Health and Safety	17	2.5
14. Abortion	31	4.6
15. Specific Concerns of the Elderly	22	3.2
16. Occupational Therapy, Physiotherapy and Rehabilitation	17	2.5
17. Drug and Pharmaceutical Concerns	20	2.9
18. Dental Care	15	2.2
19. Vision Care	13	1.9
20. Learning Disabilities	16	2.4
21. Palliative Care	9	1.3
22. Other (e.g. Nutrition, Municipal Health Boards, Disabled)	38	5.6
TOTAL	682	**100.0

* This table presents the number of recommendations made by selected topic. For example, under topic #1, a total of fifty-four (54) recommendations were made.

** May not equal 100 due to rounding.

Themes and Issues

The information contained in Tables 1 and 2 is combined in Table 3. There is also an additional column in Table 3 ranking the selected topics, excluding "Other", according to the number of recommendations received. This table shows the weighting given health care issues in submissions to the Select Committee on Health both in terms of the number of groups who made recommendations on a particular topic, and the total number of recommendations made on each topic.

The table shows that recommendations made in submissions to the Select Committee were concentrated to a considerable extent in areas of health care that people have the most contact with, i.e. hospitals and physicians. These recommendations covered a broad spectrum including how the system is financed, the type of education received by health professionals, the emphasis placed on certain types of health care, etc.

Thirty-four (34) groups and/or individuals comprising citizens, physicians, other health professionals, hospital administrators and hospital boards made 75 recommendations directly pertaining to hospitals. Across the Province these groups appeared before the Select Committee, gave the Committee tours of their facilities, and put forward recommendations concerning their hospitals. These requests included funding for new services; funding for new equipment; for both addition of hospital beds and closure of beds; renovation of some hospitals and total replacement of other hospitals including the Grace Maternity, Camp Hill, Halifax Infirmary, and St. Martha's; administrative changes, and changes in hospital policy.

The 72 recommendations made by 31 groups and individuals on the topic of Medicare and hospital insurance were concentrated in three main areas: thirty-two (32) recommendations were requests for specific additional services and/or supplies to be covered by MSI; twenty-one (21) recommendations advocated the banning of user fees and extra billing for health care services; another 10 recommendations supported the "five basic principles" of Canada's Health Insurance system; the remaining 9 recommendations concerned a variety of issues including the distribution of physicians in the Province.

As indicated in the tables, 37 groups and individuals made 54 recommendations that were classified by the Committee as: "Prevention". In some cases these recommendations were quite general. For example, recommendation 1.9 "Shift the emphasis in health care from treatment to prevention". Other recommendations were very specific such as recommendation 1.20: "Conduct pap smears and breast examinations through special clinics where not already available".

It should also be noted that the theme of prevention was stressed not only in recommendations listed directly under this topic, but in many other recommendations listed under more specific topics. For example, recommendations calling for more comprehensive health education in public schools, a higher priority for school based smoking prevention programs, and development of a sequential life sciences study program in schools, are listed under topic #7, Health Education; Human Sexuality Education and Services, but are obviously preventive programs. Topic #10, Prenatal, Perinatal and Postnatal Concerns also contains many recommendations aimed at prevention, including provision of nutritional and educational materials and counselling during pregnancy, establishment of high risk registers for pregnant women, etc. The impression made on the Select Committee by the pervasiveness of the theme of prevention is that many Nova Scotians who made presentations to the

Table 3
Combination of Tables 1 & 2

Selected Topics	Number of Groups and/or Individuals who made Recommendations by Selected Topic		Number of Recommendations by Selected Topic		
	#	%	Ranking	#	%
1. Prevention	37	28.2	3	54	7.9
2. Hospital: Administration; Construction; Services	34	26.0	1	75	11.0
3. Medicare and Hospital Insurance	31	23.7	2	72	10.6
4. Education of Health Professionals	30	22.9	4	45	6.6
5. Consumer and/or Staff Involvement in Health Policy	21	16.0	7	32	4.7
6. Home Care	19	14.5	9	29	4.3
7. Health Education; Human Sexuality Education and Services	15	11.5	6	36	5.3
8. Mental Health	15	11.5	5	39	5.7
9. Community Health Services; Expanded Entry Points	14	10.7	14	17	2.5
10. Prenatal, Perinatal and Postnatal Concerns	14	10.7	10	29	4.3
11. Environment	13	9.9	7	32	4.7
12. Specific Women's Health Concerns	11	8.4	11	24	1.5
13. Occupational Health and Safety	10	7.6	14	17	2.5
14. Abortion	10	7.6	8	31	4.6
15. Specific Concerns of the Elderly	10	7.6	12	22	3.2
16. Occupational Therapy, Physiotherapy and Rehabilitation	7	5.3	14	17	2.5
17. Drug and Pharmaceutical Concerns	6	4.6	13	20	2.9
18. Dental Care	5	3.8	16	15	2.2
19. Vision Care	5	3.8	17	13	1.9
20. Learning Disabilities	5	3.8	15	16	2.4
21. Palliative Care	4	3.1	18	9	1.3
22. Other (e.g. Nutrition, Municipal Health Boards, Disabled)	22	16.8	—	38	5.6

Select Committee on Health feel more attention should be given to the prevention of disease and accidents in our health care system.

Another theme that recurred in recommendations under many topics was the view that more appropriate, less costly, types of health care programs could be developed in Nova Scotia. In some instances these recommendations were aimed at programs for persons who would occupy relatively costly hospital beds when other less expensive methods of care could be substituted. Other recommendations concerned what some submissions felt would be better utilization of existing health professionals. The most striking example of the former were the 29 recommendations made by 19 groups or individuals on the subject of a home care program. The majority of these recommendations called for the development of a co-ordinated home care program that would include both medical and social services for persons who do not require care in an institution but cannot remain in their homes without assistance.

The majority of other issues covered by submissions made to the Select Committee are reflected in the titles of the selected topics. These subjects, issues, and problems will be addressed either specifically or within the ambit of a more general theme in succeeding chapters of the Report.

Type of Action Recommended

The final table in this chapter separates the recommendations made under each selected topic into the type of action recommended. The categories include: policy direction, i.e. the recommendation pertains to health care policy; new programs, i.e. a new program was recommended; continuation, modification, or extension (of existing health care programs or policies); study and research, i.e. more study and research of a particular topic was recommended; administrative changes, i.e. the recommended change was of an administrative nature.

Table 4 shows that 42.7% of the 682 recommendations made to the Select Committee pertained to the direction of health care policy. For example, under Prevention, recommendation 1.19, "That the principle of prevention underlie the appointment and operation of (health related) boards, commissions and committees", falls in this category. Another example of what was categorized as "Policy Direction" would be recommendation 3.1, "Recognize and protect five basic principles of Canada's Health Insurance system".

The "New Programs" category accounted for 12.6% of recommendations. Obviously a new program has a policy direction dimension as well, but to be counted in this category the recommendation had to refer specifically to a new program. For example, recommendation 5.12, under "Consumer and/or Staff Involvement in Health Policy", is "Establish a program regarding patients' rights and recourse". Recommendation 4.19, "Establish a Health Manpower Planning Office" is another example of a new program.

Category #3, Continuation, Modification, and Extension (of existing programs and/or policies) applied to 29% of all recommendations. Recommendations under this category include numerous requests for extension of MSI to cover additional supplies and services. For example: recommendation 3.7, "Insured services to include rehabilitation"; recommendation 3.10, "Universal coverage of ostomy supplies with financial limits ($300 per year) or shared costs"; 3.14, "MSI to cover medical/surgical/rehabilitative supplies for paraplegics and quadriplegics". There were also a large number of recommendations under this category that applied to the expansion of existing services. For example: recommendation 2.25, "Expand radiology and nuclear medicine services at Sydney City Hospital"; and recommendation 22.30, "Fill three currently vacant public health nutritionist positions in the Department of Health."

Twenty-eight (28) recommendations, 4.1% of the total, dealt with further study and research. Recommendations under this category covered a broad spectrum of topics. For example: recommendation 8.31, "Study the impact of unemployment on the mental health of Nova Scotians"; recommendation 11.27, "Conduct more research to identify industrial pathogenic agents in the environment"; recommendation 20.14, "Increase research on minimal brain dysfunction".

The final category, Administrative Changes, applied to 11.6% of recommendations. The largest number of these (17) recommendations pertained to hospitals and communications among various groups of health professionals. For example: recommendation 2.13, "Increase co-operation/communication between institutions, especially hospitals and homes for special care"; recommendation 7.36, "Improve communication between emergency and family medical doctors". Other "administrative type" recommendations were spread relatively evenly among the various topics.

Table 4
Selected Topics by Category

	Categories						
	(1)	(2)	(3)	(4)	(5)		*
Selected Topics	Policy Direction	New Programs	Continuation, Modification, & Extension	Study & Research	Administrative Changes	TOTAL	% of TOTAL
1. Prevention	23	17	14	—	—	**54**	**7.9**
2. Hospital: Administration; Construction; Services	25	5	28	—	17	**75**	**11.0**
3. Medicare and Hospital Insurance	42	2	21	1	6	**72**	**10.6**
4. Education of Health Professionals	23	2	12	1	7	**45**	**6.6**
5. Consumer and/or Staff Involvement in Health Policy	25	2	1	1	3	**32**	**4.7**
6. Home Care	10	12	3	1	3	**29**	**4.3**
7. Health Education; Human Sexuality Education and Services	8	—	24	—	4	**36**	**5.3**
8. Mental Health	8	6	16	3	6	**39**	**5.7**
9. Community Health Services; Expanded Entry Points	16	—	1	—	—	**17**	**2.5**
10. Prenatal, Perinatal and Postnatal Concerns	13	2	13	1	—	**29**	**4.3**
11. Environment	18	4	7	1	2	**32**	**4.7**
12. Specific Women's Health Concerns	6	4	9	4	1	**24**	**3.5**
13. Occupational Health and Safety	6	3	3	2	3	**17**	**2.5**
14. Abortion	19	—	2	2	8	**31**	**4.6**
15. Specific Concerns of the Elderly	10	3	5	4	—	**22**	**3.2**
16. Occupational Therapy, Physiotherapy and Rehabilitation	5	4	5	—	3	**17**	**2.5**
17. Drug and Pharmaceutical Concerns	8	1	3	2	6	**20**	**2.9**
18. Dental Care	3	1	9	—	2	**15**	**2.2**
19. Vision Care	8	3	2	—	—	**13**	**1.9**
20. Learning Disabilities	3	4	4	4	1	**16**	**2.4**
21. Palliative Care	2	6	—	—	1	**9**	**1.3**
22. Other (e.g. Nutrition, Municipal Health Boards, Disabled)	10	5	16	1	6	**38**	**5.6**
TOTAL	**291**	**86**	**198**	**28**	**79**	**682**	
* % OF TOTAL	**42.7**	**12.6**	**29.0**	**4.1**	**11.6**		**100%**

*Totals may not equal 100 due to rounding.

3 Health Care Financing

Introduction

Directly or indirectly the majority of recommendations made to the Select Committee on Health would have an impact on provincial government expenditures if they were implemented. However, most submissions to the Select Committee on Health did not address the impact of their recommendations on the overall level of government expenditures. In some cases it was suggested that a shift in policy direction, or the introduction of a new program would result in "expenditure savings" over the "long term". Usually the person(s) making the presentation were asked by a member of the Select Committee what the cost of the recommendations made in their submission would be, but most often such estimates were not contained in the submission itself.

Perhaps it is not surprising that the cost of delivering a service was not uppermost in the minds of many persons making submissions to the Select Committee. Their concerns were with policies and programs that would best meet specific health care problems that they perceived as requiring attention by government. However, the Select Committee on Health faced with an array of recommendations, most of which involve expenditures, was forced to consider the overall resources available for health care. In simple terms, to modify or add a health care service requires either additional (new) funds for the purpose, or the cancellation or reduction of an existing service to provide funds for the new service.

This chapter provides an outline of health care financing in Nova Scotia. It is the backdrop against which the Report was written. The first section of this chapter examines the budget of the Department of Health for one fiscal year — 1983-84. This section indicates how much the Government of Nova Scotia spends on health care in a year, and generally indicates the types of health care covered by this expenditure.

The next section briefly examines the emphasis placed upon health care in Nova Scotia as shown by Government expenditures on health compared to nine other functional areas.

The third section provides a comparison with other provinces with regard to health expenditures. Gross health expenditures, per capita expenditures, health expenditures as a percent of total government expenditures, and health expenditures as a percent of gross provincial product are compared for all provinces over the past two decades.

The fourth section contains a discussion of revenue sources available to the provincial government to cover health expenditures. Both its own source revenues, and revenue transfers from the federal government are considered in this section.

Health Expenditures in Nova Scotia: 1983-84

In 1983-84 the Nova Scotia Department of Health's budget (gross expenditure) including the Health Services and Insurance Commission, and the Nova Scotia Commission on Drug Dependency was approximately $718.9 million. An overview of how this money was spent is provided in Table 1 which is constructed from information in the Estimates of the Government of Nova Scotia.

It is readily apparent that several categories account for a large percentage of funds expended on health. The category "General Hospital Services" includes $427,581,800 for hospitals to support inpatient and outpatient services provided in accordance with the Hospital Insurance Plan, and $885,100 for administrative and maintenance activities for a total of $428,466,900. However, when other expenditures related to hospitals, such as auditing, capital debt assistance, and expenditures associated with psychiatric hospitals are included from other categories, an additional $45,967,800 in expenditures are hospital related. In total then, hospital related expenditures accounted for approximately 68% of total ordinary (current operating) expenditures on health.

Table 1
Health Expenditures in Nova Scotia 1983-84

Health Programs	**($) 1983-84 (Forecast)**
General Administration	$ 1,770,200
Finance	12,433,400
General Hospital Services	428,466,900
Psychiatric Services	34,927,800
Community Health	20,889,800
Information Systems and Research	935,800
Registration Services	524,700
Total - Health Programs	**500,064,200**
Health Services and Insurance Commission	194,138,200
Nova Scotia Commission on Drug Dependency	5,432,700
Total - Ordinary Expenditure	**699,635,100**
Total - Capital Expenditure	**19,298,600**
	$ 718,933,700

Source: Estimates of the Government of Nova Scotia: Fiscal Year 1984-85

The Hospital Services and Insurance Commission is responsible for policies and administration relating to the provision of insured health services. Maritime Medical Care Incorporated has been contracted to carry out the administration of policies set by the Commission. Administration of insured health services accounted for $6,433,200 in 1983-84, while payments to physicians, other health professionals, drugs, and other insured benefits accounted for $187,705,000 for a total of $194,138,200 as shown in Table 2. Expenditures under Medical Services Insurance accounted for approximately 28% of Total Ordinary Expenditure.

In summary, if expenditures related to hospitals are combined with expenditures under Medical Services Insurance, these functions accounted for approximately 96% of current operating expenditures in the Department of Health's budget in 1983-84. The remaining 4% of the current operating budget is divided among community health services, programs of the Nova Scotia Commission on Drug Dependency, and various administrative and support functions.

Capital expenditures by the Department of Health totaled $19,298,600 in 1983-84. Capital expenditures were $28,384,373 in 1982-83, and estimated at $30,136,600 for 1984-85. Capital expenditures cover hospital construction, renovation and equipment. Capital expenditures composed about 2.9% of the total health budget in 1983-84. Over the past decade this figure has varied considerably and this issue will be addressed in more detail in Chapter 5. To give some basis for comparison capital expenditures on health were 6.6% of the Government's total capital expenditures in 1983-84 while highways accounted for 49.5% of capital expenditures.

Table 2
Expenditures Under Medical Services Insurance (MSI)
(Health Services and Insurance Commission)

	Description	**1983-84 (Forecast)**
Administration Services		$ 6,433,200
Medical	To provide funds for the payment of physicians for insured medical benefits for all insured persons.	124,884,910
Optometric	To provide funds for the payment of optometrists for insured optometric benefits for all insured persons.	1,728,371
Children's Dental	To provide funds for the payment of dentists for insured dental services for all insured persons.	10,177,610
Pharmacare	To provide funds for the payment of pharmacies for insured pharmaceutical services for all insured persons.	26,505,260
Cystic Fibrosis	To provide funds for drugs to patients suffering from cystic fibrosis.	281,844
Cleft Palate	To provide funds for dental services to patients suffering from cleft palate.	203,630
Diabetes Insipidus	To provide funds for drugs to patients suffering from diabetes insipidus related to the pituitary gland.	45,000
Prosthetic Services	To provide funds for arm and leg prostheses.	300,000
Total - Health Services and Insurance Commission		**$194,138,200**

Source: *Estimates of the Government of Nova Scotia: Fiscal Year 1984-85.*

Gross Provincial Government Expenditures by Function

The importance placed upon health care, as reflected by provincial government expenditures on health compared to other government activities, has not changed appreciably over the past decade. This is illustrated in Table 3 and Table 4.

In Table 3 Gross Ordinary Provincial Government Expenditures (current operating) are ranked according to ten functions from 1974-75 to 1983-84. Expenditures on education and health accounted for the two largest percentages of current operating expenditures during the decade, with education ranking first, and health second, in every year except 1975-76 when the positions were reversed. On average health expenditures accounted for about one quarter (25.6%) of current operating expenditures in each year over the past decade, ranging from a high of 27.3% in 1975-76 to a low of 24.1% in 1978-79.

In Table 4 Gross Provincial Government Expenditures (current operating and capital expenditures) are ranked according to the same functions over the same time period. As would be expected expenditures on health and education accounted for the two largest percentages of total provincial government expenditures in each of these years, ranging from 22% to 25%. Health expenditures averaged 23% of total provincial government expenditures in each year over the past decade ranking first in two years and second in the eight other years.

In summary, health expenditures have remained relatively stable over the past decade both in terms of the percentage of provincial government operating expenditures, and in terms of total provincial government expenditures.

Health Expenditures: An Interprovincial Comparison

Gross Health Expenditures

Provincial Government expenditures on health from fiscal year 1974-75 to fiscal year 1983-84 are shown in Table 5. As indicated in the footnotes to Table 5, these expenditures include both operating and capital expenditures relating to public health services, medical care, and hospital care. These expenditures were calculated from provincial Public Accounts and budgets, but given different accounting procedures among provinces, the data have been standardized to facilitate interprovincial comparisons. Consequently, the expenditures for any province will not correspond exactly to the numbers found in the Public Accounts for each province.

Table 3

Gross Ordinary Provincial Government Expenditures by Functions
(Rank and Percentage (%) of Total Ordinary Expenditures)

Function/Year	**1974-75**	**1975-76**	**1976-77**	**1977-78**	**1978-79**	**1979-80**	**1980-81**	**1981-82**	**1982-83**	**(Forecast) 1983-84**
Education	1(28.3)	2(27.1)	1(28.3)	1(27.4)	1(25.3)	1(25.8)	1(24.6)	1(25.5)	1(27.2)	1(27.1)
Health	2(26.3)	1(27.3)	2(26.9)	2(25.5)	2(24.1)	2(24.9)	2(24.5)	2(25.0)	2(25.6)	2(26.7)
Services to the Public Debt	3(13.2)	3(12.3)	3(11.5)	3(10.8)	4(10.3)	3(11.2)	3(12.0)	3(12.9)	3(16.4)	3(16.7)
Social Welfare	4 (8.6)	4 (9.0)	4 (9.2)	4 (9.8)	5 (9.2)	4 (9.9)	5 (9.3)	5 (9.2)	4 (9.7)	4 (9.9)
Municipal Affairs	5 (5.8)	7 (4.5)	5 (6.9)	6 (7.1)	6 (6.8)	6 (7.6)	6 (7.6)	6 (6.4)	8 (2.8)	9 (2.1)
Transportation & Communications	6 (5.3)	6 (5.4)	7 (4.9)	7 (4.8)	7 (4.7)	7 (4.3)	7 (4.9)	7 (4.8)	6 (3.8)	6 (4.0)
Resource Development	7 (5.0)	5 (6.9)	6 (5.2)	5 (7.8)	3(12.9)	5 (9.4)	4(10.3)	4 (9.2)	5 (8.0)	5 (6.6)
General Government	8 (3.6)	8 (3.2)	8 (3.4)	8 (3.3)	8 (3.3)	8 (3.4)	8 (3.4)	8 (3.4)	7 (3.2)	7 (3.4)
Public Protection	9 (2.6)	9 (3.1)	9 (2.6)	9 (2.5)	9 (2.4)	9 (2.5)	9 (2.4)	9 (2.5)	9 (2.5)	8 (2.7)
Culture & Recreation	10(1.3)	10(1.2)	10(1.1)	10(1.0)	10(1.0)	10(1.0)	10(1.0)	10(1.0)	10(1.0)	10(1.0)
***Total (%)**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.1**	**100.0**	**100.2**	**100.2**
Total Ordinary Expenditures (thousands of $)	**822,576**	**983,078**	**1,102,065**	**1,232,083**	**1,448,660**	**1,554,960**	**1,801,734**	**2,151,987**	**2,432,823**	**2,629,106**

Note: Includes Ordinary Expenditures and Sinking Fund Installments
*Totals may not add to 100% due to rounding

Source: Province of Nova Scotia Budget

Table 4

Gross Provincial Government Expenditures by Function

(Rank and Percentage (%) of Total Gross Expenditures)

Function/Year	**1974-75**	**1975-76**	**1976-77**	**1977-78**	**1978-79**	**1979-80**	**1980-81**	**1981-82**	**1982-83**	**(Forecast) 1983-84**
Education	1(25.3)	1(23.3)	1(25.8)	1(25.2)	1(22.8)	1(23.0)	2(21.6)	2(22.1)	1(25.1)	1(25.0)
Health	2(23.1)	2(23.1)	2(24.3)	2(23.3)	2(21.5)	2(21.9)	1(21.8)	1(22.2)	2(24.2)	2(24.8)
Resource Development	5 (8.8)	3(14.8)	6 (7.6)	3(10.4)	3(14.5)	3(13.3)	3(14.9)	3(13.7)	4(10.0)	5(8.5)
Trans. & Communication	3(12.0)	4(10.3)	3(10.4)	5 (9.2)	4(11.0)	4 (9.6)	4 (9.5)	5 (9.7)	6 (7.3)	6 (8.2)
Services to the Public Debt	4(11.5)	5(10.2)	4(10.2)	4 (9.7)	5 (9.4)	5(10.0)	5(10.3)	4(11.0)	3(14.9)	3(15.1)
Social Services	6 (7.7)	6 (7.5)	5 (8.2)	6 (8.7)	6 (8.1)	6 (8.5)	6 (8.0)	6 (7.9)	5 (8.8)	4 (9.0)
Municipal Affairs	7 (5.8)	7 (4.3)	7 (6.7)	7 (6.6)	7 (6.3)	7 (7.2)	7 (7.5)	7 (6.9)	7 (3.5)	8 (2.8)
General Government	8 (3.3)	8 (2.8)	8 (3.1)	8 (3.1)	8 (3.0)	8 (3.1)	8 (2.9)	8 (3.1)	8 (3.0)	7 (3.2)
Public Protection	9 (2.3)	9 (2.7)	9 (2.5)	9 (2.3)	9 (2.4)	9 (2.4)	9 (2.5)	9 (2.3)	9 (2.3)	9 (2.3)
Culture & Recreation	10(1.4)	10(1.1)	10(1.4)	10(1.5)	10(1.0)	10(1.0)	10(1.0)	10(1.1)	10(0.9)	10(1.0)
***Total (%)**	**100.0**	**100.0**	**100.2**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total Gross Expenditures	**945,118**	**1,179,923**	**1,247,868**	**1,377,857**	**1,650,306**	**1,793,258**	**2,094,855**	**2,523,173**	**2,690,235**	**2,938,722**

(thousands of $)

Note: Gross Expenditures include Ordinary Expenditures, (Current Operating) and Capital Expenditures, Sinking Fund Installments and net increases in Capital Advances and Investments.

*Totals may not add to 100% due to rounding

Source: Province of Nova Scotia Budgets

From Table 5 it can be seen that in 1983-84 health expenditure estimates ranged from approximately $7.7 billion in Ontario to a low of approximately $84 million in Prince Edward Island. Nova Scotia ranked seventh compared to other provinces with health expenditures estimated to be approximately $697 million. The Table shows that the ranking of Provinces according to the absolute level of health expenditures has changed only marginally during the past decade.

Per Capita Health Expenditures

A more useful comparison of health expenditures is shown in Table 6 where health expenditures by province have been divided by the population of each province to yield provincial health expenditures per capita. These figures show that in 1983-84 Alberta had the highest health expenditures per capita with $1,257.91, while Prince Edward Island had the lowest with $754.84. Nova Scotia ranked sixth with per capita expenditures of $810.66. An examination of Table 6 reveals that the ranking of provinces in terms of per capita expenditure has changed very little over the past decade. Nova Scotia has consistently ranked sixth or seventh among provinces in terms of per capita expenditure except in 1977-78 when Nova Scotia ranked fourth. This pattern also holds for the 1960's and early 1970's when Nova Scotia ranked as high as fourth and as low as ninth, but ranked sixth or seventh for most of the period.

Health Expenditures as Per Cent of Government Expenditures

Table 7 presents provincial government health expenditures as a per cent of gross general expenditures of each provincial government from fiscal 1974-75 to fiscal 1983-84. Using these standardized statistics which differ slightly from those used in Table 4, Nova Scotia's health expenditures have ranged from a high of 26.7% of gross general expenditures, in 1977-78, the second highest percentage in Canada, to a low of 22.3% in 1978-79 when Nova Scotia ranked third among provinces using this measure.

On average, over the decade, health expenditures accounted for 23.9% of gross general government expenditures in Nova Scotia placing the Province fourth compared to other governments. This measure suggests that a greater emphasis has been placed on health care in Nova Scotia than was evident from other statistics outlined above.

It is also interesting to note that the average percentage of gross general government expenditures devoted to health in Nova Scotia over the previous decade, 1964-65 to 1973-74, was 24.8%. However, over the last seven years of this period Nova Scotia ranked sixth or seventh, compared to other Provinces. It can be concluded from these figures that while Nova Scotia has devoted a slightly lower proportion of gross general government expenditures to health during the decade 1974 to 1984 compared to the previous decade, Nova Scotia has nevertheless ranked fourth, on average, compared to other Provinces. Nova Scotia's relatively high ranking in terms of the percentage of government expenditures devoted to health care can be explained to some extent by the fact that specialized health facilities for the Maritime region are located in Halifax.

Table 5
Provincial Government Health Expenditures (1) (2)
$ Millions

	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
1974-75	160.3	28.2	228.2	169.6	1,957.6	2,677.1	307.5	229.7	546.0	732.9
1975-76	188.8	34.6	277.6	203.3	2,404.5	3,144.3	366.1	285.5	727.1	954.6
1976-77	196.1	38.7	303.5	232.1	2,741.4	3,439.2	431.1	347.5	936.2	1,044.0
1977-78	204.7	49.7	387.5	255.6	2,826.5	3,726.0	592.9	450.9	909.1	1,142.9
1978-79	231.4	49.1	369.6	280.9	3,219.9	4,069.0	508.1	423.1	1,051.3	1,365.5
1979-80	252.9	52.5	407.9	310.5	3,643.2	4,343.0	546.3	476.5	1,246.3	1,571.9
1980-81	298.7	61.0	464.6	334.2	3,795.6	4,915.6	640.7	537.1	1,599.6	1,823.3
1981-82	344.2	63.5	537.6	407.6	4,393.6	5,738.1	720.4	593.9	1,924.9	2,163.6
1982-83	404.9	74.7	626.8	501.6	5,370.7	6,733.5	924.7	709.9	2,565.8	2,576.1
1983-84	450.0	93.6	696.6	559.0	5,689.4	7,716.9	1,028.4	773.8	2,956.1	2,836.2

(1) Includes operating and capital expenditures relating to Hospital Care, Medical Care, Preventative Care and Other. Data originates from provincial public accounts and budgets.

(2) Data originated from Provincial Public Accounts and Budgets. However, the application of financial management concepts is such that differences exist between data presented in Provincial and Territorial Accounts and Gross General Revenue and Expenditure. For information on the nature of these adjustments see Statistics Canada Publication 68-207.

Source: Statistics Canada Cansim Data Retrieval System

Table 6
Provincial Governments - Health Expenditures Per Capita*
($'s)

	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
1974-75	296.03	244.79	281.21	259.49	319.73	332.39	305.21	255.31	317.00	308.50
-76	343.84	295.47	338.74	305.62	389.14	384.76	361.19	314.63	408.87	392.32
-77	351.62	327.41	366.28	342.73	439.72	416.14	422.03	377.18	509.36	423.25
-78	365.67	416.60	464.96	373.63	449.79	446.06	477.09	482.30	475.30	457.27
-79	412.11	405.79	441.31	408.23	510.90	482.13	492.34	448.44	530.13	537.11
1979-80	448.80	430.33	484.56	448.76	574.74	510.86	531.42	500.89	607.12	607.05
-81	528.11	496.74	549.76	480.59	594.35	573.60	625.13	559.83	747.27	683.91
-82	606.31	518.37	634.29	585.30	682.43	665.31	702.01	613.34	860.37	788.43
-83	711.35	608.31	735.51	717.49	828.50	772.56	893.26	724.83	1,107.38	923.30
-84	778.68	754.84	810.66	791.00	872.39	875.34	982.06	779.49	1,257.91	1,004.36

* derived by dividing health expenditures for the fiscal year by the June 1 population.

Source: Statistics Canada, Cat.

Table 7
Provincial Government Health Expenditures as a Percent of Gross General Expenditures

	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.
1974-75	20.2	17.0	25.0	20.1	24.6	27.7	26.7	21.3	23.1	25.2
1975-76	19.2	16.9	24.8	19.9	24.6	27.4	25.9	21.6	24.2	25.2
1976-77	18.3	18.3	24.5	20.8	23.9	27.0	26.7	22.1	25.2	26.5
1977-78	18.5	19.0	26.7	20.9	21.9	26.6	31.0	24.8	21.9	25.6
1978-79	15.8	17.9	22.3	20.8	22.0	26.7	27.5	21.7	21.9	27.5
1979-80	16.8	17.4	23.3	21.1	22.2	26.2	25.9	20.9	18.4	27.9
1980-81	19.4	18.1	22.9	19.8	19.9	27.6	26.5	22.0	24.4	28.6
1981-82	20.0	16.9	22.9	21.3	20.4	28.5	26.9	20.9	23.9	30.2
1982-83	20.2	17.9	23.2	21.1	21.3	29.0	28.9	21.1	23.9	31.1
1983-84	21.2	21.5	23.8	21.9	21.4	30.2	26.6	22.3	23.3	30.1
Average (1974-75 to 1983-84)	19.0	18.1	23.9	20.8	22.2	27.7	27.3	21.9	20.6	27.8
Rank	9	10	4	7	5	2	3	6	8	1

Health Expenditures as a Percent of Gross Provincial Product

Gross Provincial Product (GPP) is an estimate of the dollar value of the goods and services produced in a province in a given year. In a sense, GPP is a proxy for the relative prosperity of a province. Given that the Maritime Provinces and Newfoundland have not traditionally been as "well off" as some other Canadian provinces it would be expected that health expenditures in these provinces would constitute a higher percentage of the value of goods and services produced in these provinces if a comparable level of health care is provided there. As shown in Table 8 this is indeed the case.

In fiscal 1983-84 Nova Scotia's expenditures on health were 8.1% of the Gross Provincial Product compared to the average for all provinces in that year of 6.3%. In fact Nova Scotia has exceeded the all provinces average for the past twenty years. Nova Scotia has had the second or third highest percentage compared to other provinces during most of the past decade and has never ranked lower than fourth going back to 1961-62.

It is not surprising that health expenditures are a higher percentage of provincial resources in disadvantaged provinces compared to wealthier provinces. The difficulty that disadvantaged provinces would have providing health care of comparable quality to health services available in wealthier provinces was an important reason for the revenue Equalization Program. However, for the future it is obvious that new health services cannot be introduced in Nova Scotia, or the other Atlantic Provinces without placing an even heavier burden on scarce resources **unless** additional funding for new health services is forthcoming from the federal government.

It may appear that this is a self serving conclusion, however it should be noted that the federally appointed Hall Commission reached the same conclusion nearly four years ago. The following quote is from page 13 of **Canada's National-Provincial Health Program for the 1980's "A Commitment for Renewal"**:

> "It follows from the foregoing that a number of Provinces, particularly the four Atlantic Provinces cannot hope to expand their health services into other areas such as drug and dental programs, for example ..... the solution insofar as the have not Provinces are concerned is for the Federal Government to cost-share the additional insured services that these provinces wish to institute."

Provincial Government Revenue

The purpose of this section is to briefly outline Provincial Government revenue sources from which health expenditures in Nova Scotia are covered. Table 9 contains Gross Provincial Revenue by source for 1983-84. The main sources of revenue as shown in the table are equalization payments (25.2%), income taxes (21.4%), the health services tax (15.4%), and Established Programs Financing (12.1%).

Although revenues from any of the sources listed in Table 9 could be utilized to cover health expenditures, one revenue source, the health services tax, is specifically earmarked to cover health expenditures. Established Programs Financing was set up to fund expenditures for health and post secondary education, and equalization payments are made to "have not" provinces to help cover expenditures on public services, one of which is health.

Table 8
Provincial Governments - Health Expenditures as a Percent of Gross Domestic Product*
(%)

	Nfld.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Average All Provinces
1974-75	8.94	7.75	6.97	6.41	6.34	5.10	5.57	3.99	4.02	4.77	5.33
1975-76	9.30	7.54	7.38	6.57	6.77	5.38	5.83	4.28	4.31	5.64	5.71
1976-77	8.24	7.68	7.13	6.77	6.70	5.12	6.11	4.73	4.77	5.18	5.61
1977-78	7.74	9.31	8.34	6.96	6.40	5.09	7.96	5.89	3.99	5.11	5.58
1978-79	8.17	7.83	7.14	6.77	6.53	5.06	6.05	4.72	3.90	5.43	5.46
1979-80	7.30	7.31	7.04	5.96	6.55	4.78	5.78	4.73	3.79	5.30	5.27
1980-81	8.15	7.53	7.23	6.31	6.02	4.85	6.23	4.56	4.04	5.45	5.24
1981-82	8.41	7.18	7.43	6.79	6.11	4.96	6.14	4.42	4.43	5.67	5.40
1982-83	9.01	7.85	8.07	8.01	7.28	5.57	7.28	5.05	5.47	6.47	6.24
1983-84	9.25	8.87	8.13	8.14	7.10	5.77	7.46	4.97	5.93	6.53	6.34

*GDP at Factor Cost for previous calendar year - i.e. Health expenditures for 1978-79 as a % of 1978 G.D.P.

Source: Statistics Canada, Cat. 68-207; Conference Board of Canada

The Health Services Tax rate in Nova Scotia has been 10% since April 30, 1982. In 1983-84 revenues from this tax are forecast to be $370,000,000. As noted above, in terms of percentage of total revenues, the health services tax is the third most important revenue source overall, and excluding federal transfers is the second most important, surpassed only by income taxes.

Established Programs Financing (E.P.F.) is federal funding transferred to all provinces to contribute to the coverage of provincial expenditures for the three major programs of medicare, hospital insurance, and post-secondary education. E.P.F. funding consists of a per capita cash payment, and a transfer of the value of 13.5 percentage points of personal income tax and 1 percentage point of corporate income tax to the provinces.

Table 9
Gross Revenues By Source
($000)

Source	1983-84 (Forecast)	Percent of Total
Income Taxes	513,305	21.4
Health Services Tax	370,000	15.4
Motive Fuel Taxes	106,800	4.5
Liquor Commission Profits	73,100	3.1
Interest Revenues	75,281	3.1
Registry of Motor Vehicles	33,547	1.4
Other Provincial Sources	141,543	5.9
Equalization	602,818	25.2
Established Programs Financing	291,011	12.1
Other Federal Sources	188,581	7.9
	2,395,986	100.0

Source: *Budget Address Nova Scotia 1984-85*

E.P.F. block funding began with the passage of the **Federal-Provincial Fiscal Arrangements and Established Programs Financing Act** in 1977. Prior to 1977 expenditures for medicare, hospital insurance, and post-secondary education were cost-shared (on a 50-50 basis) between the federal government and the provinces. The key reasons for the change from "cost sharing" to "block funding" for these "established programs" was that the federal government did not want to "track" provincial expenditures in these areas, and provincial governments were given the flexibility to spend the funds in health and post secondary education fields according to their own priorities rather than under cost sharing guidelines set by the Federal Government. **The Fiscal Arrangements Act** was amended in December 1982, and can be amended by the federal government at any time, although three years notice is required before cancellation of the Arrangements.

The figure shown for Established Programs Financing in Table 9 represents the per capita cash payment to Nova Scotia in fiscal 1983-84. Although there is no requirement for any particular proportion of this to be devoted to health care, the federal government, for accounting purposes, uses arbitrary shares based on 1975-76 expenditures to split the payment into $208,396,000 for the health component with the remainder attributed to post secondary education. However, actual provincial utilization does not necessarily follow this arbitrary federal allocation.

Equalization payments are unconditional grants from the federal government to eligible provincial governments. The objective of the equalization system is to ensure that all provinces are able to provide their citizens with a reasonably comparable level of basic services without resorting to unduly burdensome levels of taxation. Equalization payments are based on revenue raising capacities (38 different revenue sources) of the provinces, but are financed by the federal government. Implicit equalization provisions have existed since 1947, but the explicit equalization system dates from 1957, and the current equalization system is set out in Part I of the **Federal-Provincial Fiscal Arrangements and Established Programs Financing Act 1977** as amended in December 1982. The current equalization program is due to expire March 31, 1987.

The figure for equalization payments shown in Table 9 ($602,818,000) represents the total equalization payment to Nova Scotia. This payment is not earmarked specifically for health services, although health would certainly be one of the "basic services" referred to in the objective to the program.

Annual percentage changes for health expenditures in Nova Scotia, and annual percentage changes in Gross Provincial Revenues, Health Services Tax, E.P.F. payments, and Equalization payments are shown in Table 10. These percentages are given starting in 1978-79 since Established Program Financing started in 1977-78, hence 1978-79 is the first year that a percentage could be calculated. **The table shows that except for health service tax revenue, health expenditures have increased faster on average than revenue sources potentially earmarked for health expenditures.** In the case of the Health Services Tax the 33.3% increase in 1982-83 can be explained by the increase in the sales tax rate from 8% to 10%.

Table 10
Annual Percentage Changes in Health Expenditures and Selected Revenue Sources

Fiscal Year	Health Expenditures	Provincial Revenues	Health Services Tax	E.P.F.	Equalization
1978-79	11.4	11.5	13.4	16.5	2.5
1979-80	11.0	12.0	18.0	13.8	15.4
1980-81	14.1	10.7	4.2	8.4	8.5
1981-82	21.7	12.3	4.3	8.4	21.0
1982-83	15.5	9.8	33.3	4.6	12.2
1983-84	12.7	10.2	18.6	17.6	-2.2
Average	14.4	11.1	15.3	11.6	9.6

Source: *Selected Budget Addresses: Nova Scotia*

Note: Percentage changes are calculated from total gross health expenditures, total gross provincial revenues, and the cash portion of Established Programs Financing allocated for health care.

Summary

Statistics show that in relative terms - i.e. as a percentage of total provincial government expenditures - expenditures for health services have been remarkably stable over the past twenty years. Compared to other provinces Nova Scotia's emphasis on health care, as reflected in the proportion of the provincial budget devoted to this service, has been strong, ranking fourth on average over the past decade. Health expenditures constitute a large percentage of Gross Provincial Product in Nova Scotia and the introduction of new health services in the province will require additional federal funding if a heavier burden is not to be placed on already limited resources. On the revenue side, the average increase in total provincial revenues since 1978-79 has not kept pace with the rate of increase in health expenditures. In particular federal transfers for health services have lagged behind increases in health expenditures; only provincial Health Services Tax revenues have grown faster than health expenditures.

Recommendations

The Select Committee on Health recommends:

1. **That the Federal Government be encouraged to provide appropriate funding to Nova Scotia to help cover the costs of additional required health services.**

2. **That the Federal Government be encouraged to co-operate in providing appropriate funding mechanisms for services to be provided through a comprehensive co-ordinated home care program (see chapter 6) in Nova Scotia.**

4 Prevention

Introduction

As indicated in Chapter 2 more groups and individuals referred to "prevention" in their submissions to the Select Committee on Health than any other single issue. There was also a prevalence of recommendations of a preventive nature appearing under other topics. It was clear to the Select Committee from the emphasis given to prevention in submissions, and from the desire to explore health strategies for the future, that prevention should be addressed in this Report. This chapter provides background material on the subject of prevention and concludes with recommendations.

Defining Prevention

For the purposes of this Report, prevention has been defined as programs and services which avert the occurrence of disease, illness, or dysfunction and which promote the optimal health of a population. Preventive health programs can be categorized into three levels of prevention - primary, secondary and tertiary.[1]

Primary prevention describes actions which are taken so that a disease or injury does not occur. Examples include the avoidance of smoking to prevent lung cancer, and moderating caloric intake to prevent obesity. **Secondary prevention** is the early diagnosis of disease which permits more effective treatment. An example is screening for breast cancer to identify an early stage of disease so that treatment can be more effective. **Tertiary prevention**, which should not be confused with acute care, is defined as maximal rehabilitation from disease and subsequent therapy[2]. The discussion of this chapter will focus on primary and secondary prevention.

Increasing Emphasis on Prevention

Prevention has always been a major theme in health care. However, in terms of expenditures, prevention has until relatively recently been a secondary concern in the health care system with the emphasis being on curative medicine and treatment.

Within the last ten to fifteen years, more attention has been turned to the preventive side of health care as costs continued to rise, and analysis of morbidity and mortality demonstrated that increasing expenditures in traditional areas had little effect on the health status of the population as measured by these indicators. Despite modern medicine's ability to improve the quality of life by reducing suffering, and ameliorating the effects of illness, the rate of improvement according to traditional indicators of health or illness has dropped off dramatically; there seems to be no relation between the rate of increase of resources spent in curative health care and progress made toward lengthening life expectancy or reducing the death rate.[3]

"A New Perspective on the Health of Canadians" published by Health and Welfare Canada in 1974 provided a very strong statement on prevention and strategies for the improvement of health. This document stated that improvements in health over the last two centuries have been due mainly to modification of behaviour, changes in the environment (i.e., increases in food supplies and a healthier physical environment) and some specific preventive and therapeutic measures. It suggested that improvement in the environment, an abatement in the level of risks imposed by individuals on themselves, and additions to our knowledge of human biology hold the greatest hope for future advances in health status.[4]

Other studies and reports at the provincial, federal and international levels also lend support to this viewpoint. These reports include: The Nova Scotia Council of Health Report in 1972; the 1980 Hall Commission Report, "A Commitment for Renewal"; and recent publications of the World Health Organization and the United States Department of Health and Human Services.[5]

Difficulties with Prevention

In 1973-74 the Graham Commission observed that approximately five per cent (5%) of total health care costs were devoted to the Department of Health's programs of prevention, health education, and rehabilitation.[6] An estimate of the Province's expenditure on preventive programs for the fiscal year 1983-84 reveals that the situation has not changed appreciably in the past decade. Expenditures for Community Health (which includes Health Unit Services, and services provided under the previous Environmental Health Division, minus the ambulance subsidy program), plus expenditures for rehabilitation services, and the Nova Scotia Commission on Drug Dependency, were approximately four per cent (4%) of the total ordinary expenditure of the Department of Health.[7]

What difficulties have kept "prevention" from achieving the stature suggested in the foregoing reports? Aside from any resistance to change that might exist in the broadly defined medical community, and the sheer difficulty involved in re-orienting such a vast and complex health care system, there are several problems associated with preventive health care. These problems include first, the establishment of proof that preventive health care yields substantial cost savings and is not simply an additional expense in the system; and second, the identification of specific preventive programs that can be implemented in the health care system.

With regard to the second problem, it has also been suggested that to be successful preventive programs must branch out from the traditional health care system. That is, greater emphasis should be placed on health education and social services programs. Examples include the involvement of health educators and nutritionists in day care programs, and in the curriculum branch of the Department of Education.

These problems are addressed below by examining the causes of death and disease, by looking at the costs to society of premature death and disease, and finally by a review of studies that have been done to determine the effectiveness of preventive programs.

Morbidity and Mortality

In Canada and other industrialized developed countries the causes of death and disease have undergone profound change since the turn of the century. Of the ten major causes of death in 1900, six were either infectious or related to infectious processes. In

1970 none of the ten major causes of death were infectious except influenza-pneumonia and certain diseases of early infancy.[8] This is also the case in the United States where chronic diseases with complex etiologies, accidents and violence lead the causes of mortality and account for considerable morbidity.[9]

Death rates and morbidity vary according to sex and age group. The major cause of death, particularly for males, in both the 1-14 and 15-24 age group is motor vehicle and other accidents. For the 24-44 year age group, the main causes of death are accidents, ischaemic heart disease and suicide. For the age group 45-64, male death rates are dominated by ischaemic heart disease, respiratory diseases and cancer of the lung and digestive system.[10] In 1978 for all ages and both sexes the major causes of death in Canada were in order: ischaemic heart disease; cerebrovascular disease; malignant neoplasm of digestive organs; respiratory diseases and lung cancer; motor vehicle and all other accidents; suicide; malignant neoplasm of the breast; cirrhosis of the liver; and diseases of the nervous system and sense organs. These causes accounted for 71.2% of all deaths.[11]

In general, in studies on the subject, it is argued that environment and behaviour play a large determining role in the cases of death listed above, particularly premature mortality. A recent U.S. Department of Health and Human Services publication noted that "of the ten leading causes of death in America, smoking is a significant factor in four, ... alcohol can be a factor in six, ... and diet is a factor in four. Behavioural choice is a factor in every one of the ten leading causes of death."[12]

The Cost of Ill-Health

The costs to society of having to deal with premature death and disease are enormous both in terms of the dollars spent in treatment and rehabilitation, and in terms of the loss of human resources. The Ontario Council of Health attempted to estimate the economic burden of ill-health in 1976 to facilitate the process of establishing priorities in the Province's funding for health research. Using 1971 data, both the direct burden of ill-health (cost of hospital services, physicians' services, dental services and pharmaceuticals) and the indirect burden, or the primary value of the loss of labour inputs stemming from mortality and morbidity, were calculated for eighteen diagnostic categories.

This study estimated that five diagnostic categories (circulatory, accidents, mental, digestive and neoplasms) accounted for $1,870,770,314 or 62.9% of the total cost of ill-health in Ontario in that year.[13] If it is assumed that the distribution of illness is approximately the same for Nova Scotia as Ontario, it is obvious that even a modest reduction of 10 to 15 per cent in the incidence of the diseases listed would result in substantial savings to the Province.

A specific example of the cost of ill-health that is worth developing in considerable detail is the potential impact of nutrition during pregnancy.[14] It is well known that proper nutrition provides the essential elements for growth and development and since the rate of growth is greater in utero than at any other time in the life cycle the impact of nutrition is most traumatic during pregnancy. The following example illustrates the potential costs of ignoring this important factor.

In 1981, Canada ranked eighth of 25 developed countries in infant mortality with a rate of 9.6 per 1,000 live births.[15] There is evidence that morbidity may be even more extensive, and one study estimates that in 1,000 births 28 will survive with one or more disabilities.[16] If one considers that in 1982, Canada recorded a total of 373,082 live births,[17] assuming a disability incidence of 28 per 1,000, there were 10,446 infants born with one or more handicaps.

The connection with nutrition is that low birth weight is considered to be a major contributor to the occurrence of disabilities.[18] [19] [20] Two nutritionists, Bergner and Susser, reviewing data on prenatal nutrition stated that: "Low birth weight is well established as an antecedent of excess mortality in infants and of mental retardation and other neurological disorders. The lower the birth weight, the greater is the perinatal death rate and the higher is the incidence of brain disorders and of mental retardation."[21] In turn it has been shown that adequate nutrition throughout pregnancy has a significant impact on birth weight of the baby. [22] [23] Caloric adequacy as evidenced by an appropriate mean weight gain between 11-13 kg, significantly reduces the incidence of low birth weight infants. [24] [25] [26]

The health care costs associated with caring for handicapped infants can be extremely high. It has been estimated that around the clock care in neonatal units costs approximately $1,000 per day and some babies require as much as $150,000 in health care expenditures before they leave the hospital to go home.[27] This is not the end of the costs associated with these infants. As they grow older many of these children will require special education classes and other assistance in order to learn.[28] Total costs to society have been conservatively estimated to be $500,000 per person.[29] [30] In terms of the 10,466 infants estimated to have been born in Canada with handicaps in 1982, this would mean $5.2 billion. Even if a modest reduction such as 10% of these disabilities is possible through improved nutrition during pregnancy, society as a whole could save approximately $520 million. In any event, the actual dollar figure is not as important as the principle developed in the foregoing example.

Another example of a costly, potentially preventable disease is alcoholism. Alcoholism is a chronic disease in itself and leads to other diseases and disease complications including liver disease, ulcers, neurological diseases, and the onset of various cancers. Alcoholism is also a major factor in traffic accidents. Other problems arising from alcoholism include industrial accidents, drop in performance and consequent loss of employment, and social problems including family breakdown.[31]

It has been estimated that 1.4 million Canadians, or one adult drinker in 10, now suffer from an alcohol related handicap. For the year 1978 it has been estimated that 18,000 deaths, or 10.9% of all deaths in Canada in that year, were linked with alcohol consumption.[32] Costs related to alcoholism include costs associated with hospitalization for traffic accidents, and the alcohol related diseases listed above. These include surgical costs in advanced cases. Social costs associated with alcoholism include wife battering, other criminal acts, and family breakdown.

Another example where there is some scope for cost reductions and prevention of disease is diabetes mellitus. Deaths due to diabetes mellitus are one of the leading causes of death in Canada in age groups 65 years and over. Diabetes is also associated with many other diseases including eye disease, renal disease, coronary disease, peripheral vascular disease, and neurological disease. The incidence of the adult onset of diabetes increases with physical idleness and obesity. In the case of diabetes it is important to screen to pick up new cases as early as possible, reduce weight to decrease the severity of the disease, eat properly, and exercise regularly. The last three factors can help to control, or even eliminate the disease in some cases. Controlling or eliminating diabetes would reduce drug costs, and costs of treating the chronic diseases listed above which are associated with diabetes.

The Effectiveness of Preventive Programs

This section reviews evidence on the effectiveness of preventive actions in terms of their impact on health status, and their relative cost. Information relating to the effect of preventive measures on health status is readily available. Studies regarding benefit-cost aspects of prevention programs are less common. This appears to be an area of health economics that has not yet received a great deal of attention.

Immunizing vaccines are an example of a very effective preventive medicine practice, both in absolute terms and in comparison to therapeutic medicine.[33] Benefit-cost analyses of immunization programs in the United States have been conducted to assess: the efficacy of the vaccine; the cost of administering the vaccine; the benefits from the reduced incidence of the disease; and the cost of side effects. When compared to the health benefits, the monovalent rubella program appears to have a benefit-cost ratio of about 25 to 1 when given to females at the age of 12 with 100% compliance.[34] The benefit-cost ratio of a combined rubella, measles, mumps vaccine is very high, as the costs are about the same as for a single vaccine.[35]

The evidence on the effectiveness of **screening** shows that the benefit-cost relationships found in screening programs for phenylketonuria, congenital hypothyroidism and spina bifida cystica were favourable. Multi-phasic screening programs for certain age groups may also result in benefits that exceed costs. In addition, there is preliminary evidence that the benefit-cost ratio of screening and treatment for hypertension and cancer of the colon and rectum could be favourable, particularly for high risk populations.[36] As suggested earlier, screening of pregnant women for eating habits, weight gain, smoking and drug use, could also have a major impact.

A great deal of attention has recently been given to the topic of healthful **lifestyles**, i.e. those aspects of living over which the individual has some control. There is a growing body of evidence suggesting that individuals who have healthful habits have lower morbidity and mortality rates than individuals who smoke, drink excessively, are over- or underweight, have poor nutrition habits, get too little sleep, get too little exercise, or live tense lives.[37] Of these habits the relationship between smoking and health is most clearly established, particularly the relationship between smoking and the incidence of certain types of cancer, as will be discussed in more detail in the next section.

Because **nutrition** is a factor which affects almost every bodily function, it is difficult to establish an exact cause and effect relationship to health and disease. However, nutrition appears to be an important factor in a large number of health concerns. Nutrition is important at every stage of the life span but has its most significant impact in the following cases:[38]

Pregnancy outcomes: As indicated in the previous section, improved maternal diet and nutritional status can reduce fetal wasting, can improve birth weights, and can reduce the incidence of mental retardation and handicapping conditions in children.

Infant and Child Health: Improved diet can enhance mental and physical growth and development in infancy and childhood. It can also reduce dental caries.

Elderly: Improved food intake appears able to reduce the incidence of immobility, heart disease and diabetes.

Atherosclerosis: Improved food intake can play a major role in reducing heart disease, stroke, cardiovascular disease, and related problems such as diabetes.

Cancer: Improved food intake can reduce susceptibility to cancer. It is estimated that 60% of all female cancers and 40% of all male cancers are related to diet and nutrition.

Obesity: Improved food habits can reduce the risk of developing obesity, which in turn can reduce the risk of developing hypertension and maturity onset diabetes.

Other examples of prevention, particularly primary prevention which do impact on risk factors and result in improvements in health status include:

Child-resistant drug containers: The use of child-resistant drug containers resulted in a drop of 30% in one year in mortality among children under five from the ingestion of aspirin and related compounds.[39]

Lower Speed Limits: Motor vehicle accident fatalities in the United States dropped by 20% with the introduction of the 55-mile per hour speed limit.[40]

Seat Belts: Mandatory seat belt legislation in Ontario resulted in a 17% reduction in fatalities and a 13.7% decrease in injuries in the first year of implementation.

Fluoridation: Fluoridation of drinking water has shown a 65% reduction in tooth decay among children.[41]

Clearly, specific preventive health programs can impact positively on the health status of individuals. Although the application of cost-benefit analyses to these programs is still in its infancy, indications are that preventive programs do have the potential to moderate the increase in health care expenditures.

Prevention and Health: Developing a Strategy

Any prevention strategy must be based on an appreciation of the causes of death and morbidity and the role played by various risk factors on mortality or morbidity. A useful measure of the impact of premature mortality is Potential Years of Life Lost or PYLL. PYLL or Potential Years of Life Lost is an index used to measure premature mortality. The method of calculation of PYLL consists simply of a summation over all age groups between 1 and 70, of the number of deaths at a specific age multiplied by the remaining years of life up to age 70. For example, a death at age 30 from a particular cause contributes 40 years to the total potential years of life lost due to that cause.

Using this measure of mortality it can be seen that cancer of the trachea, bronchus and lung accounted for 5.7% of all deaths in Canada between the ages of 1 and 70 in 1974, and 3.39% of all PYLL.[42] For the same year, it has been calculated that 63.4% of lung cancer deaths and 61.4% of corresponding PYLL were attributable to cigarette smoking.[43] In this case cigarette smoking constitutes a very substantial risk that the smoker will contract one of three forms of cancer. If a significant proportion of the population can be convinced to stop or reduce smoking, it follows that cancer of the trachea, bronchus and lung will account for fewer deaths and less PYLL.

In 1981 a Federal/Provincial/Territorial Ad Hoc Committee on National Health Strategies was established by the Conference of Deputy Ministers of Health to review health status of Canadians, identify priority problem areas, and propose related goals and strategies. The Report of the Ad Hoc Committee used an approach to identify major health problems that was similar to the approach outlined above. Various indicators of mortality, morbidity, and disability were used in order to identify the major health problems affecting the health status of Canadians. Using this approach, the following seven health problems were identified as priority concerns:[44]

- Accidents
- Arthritis and joint disorders
- Cancer
- Cardiovascular and cerebrovascular diseases
- Maternal and infant health problems
- Mental disorders
- Respiratory diseases

Each of these problem areas was then examined to identify the factors contributing to it, goals were established, and strategies relating to health risk reduction for each problem were suggested. For instance, cardiovascular and cerebrovascular diseases are among the leading health problems in persons over the age of 40. Many factors contribute to these conditions, including: smoking, hypertension, diabetes, obesity, stress and genetic pre-disposition. Strategies that could contribute significantly to the reduction of cardiovascular and cerebrovascular disease include:

- Promote programs to make smoking socially unacceptable, particularly among young people in public places;
- Promote greater awareness among the public of stress situations and methods of coping with them;
- Promote healthy dietary habits by people of all ages, teach good eating habits in the schools, and provide better prenatal nutrition counselling;
- Develop and implement improved methods for the early detection and treatment of hypertension; and
- Identify the cultural and social determinants of patients' behaviour and promote sensitivity to these factors in prescribing treatment and rehabilitation regimes.[45]

The preceding list provides only a sampling of the suggested strategies which generally fall into five major areas:

- Health risk reduction
- Early detection of health problems
- Treatment
- Rehabilitation
- Research, evaluation and data collection

A similar exercise undertaken in Nova Scotia would identify significant risk factors which could subsequently be used to establish a health prevention strategy for the Province.

Summary

Overall it was the view of the Select Committee that the balance between preventive health programs and the curative care system must be tipped more in the direction of prevention. The development of an overall prevention strategy is a major step in this direction, but there are also specific steps that can be taken immediately. The recommendations reflect this overall philosophy that more emphasis must be placed on prevention in Nova Scotia; the recommendations also embody both immediate and longer term processes aimed at putting this philosophy into practice.

Recommendations

The Select Committee on Health recommends:

1. **That health care programs and services of a preventive and health promotion nature be given a higher priority by the Government of Nova Scotia.**

2. **That a Committee be established under the Chairmanship of an official of the Department of Health to devise a preventive health strategy for the Province of Nova Scotia. The Committee should follow the approach utilized by the Federal/Provincial/Territorial Ad Hoc Committee on National Health.**

   The development of a prevention strategy for the Province of Nova Scotia requires careful consideration and planning based on the Province's needs and resources. The establishment of a committee to facilitate this process is similar to the approach used in some European countries to develop preventive programs appropriate to their needs.

   The Committee should consist of seven (7) members drawn from the Department of Health, voluntary agencies involved in preventive health care, the Department of Community Health and Epidemiology at Dalhousie University, and persons expert in the field of preventive health care.

   This Committee should be given the resources to examine appropriate demographic, epidemiological, and program material necessary to establish clear goals in program components for a preventive health strategy for Nova Scotia. The Committee should make a public report directed to the Minister of Health, within twelve (12) months of its establishment.

3. **That sufficient resources be provided to review and evaluate, at regular intervals, the effectiveness of the programs constituting the preventive health strategy developed for Nova Scotia.** This procedure should provide some indication of the effectiveness of the programs that make up the preventive health strategy, and provide the flexibility to modify and/or change programs as required.

4. **That mandatory seat belt legislation be proclaimed in the Province of Nova Scotia.**

5. **That the citizens of Nova Scotia be provided with no smoking environments in specific public places, giving major emphasis to the work site, transit systems, hospitals, child care centres, educational institutions, and all government accommodations.**

6. **That the Government of Nova Scotia discourage the use of tobacco.**

7. **That voluntary organizations which have proven to be effective in developing and implementing significant smoking cessation programs be encouraged and supported.**

8. **That stiffer penalties be enacted for impaired driving.**

9. **That blood testing for impairment be made mandatory in the case of a reportable accident.**

10. **That consideration be given to lowering the permissible levels of drug use, including alcohol, related to vehicle operation.**

11. **That a physical fitness program be offered in the schools from grades primary through twelve on a daily basis to provide children with a foundation upon which to build a healthy lifestyle.**

12. **That the Department of Education provide for the inclusion of a comprehensive health education (sequential life sciences study program) program from grades primary through twelve.**

13. **That prenatal education services available to the public be improved and that health care workers be encouraged to carry out health promotion counselling of prenatals in the areas of smoking, nutrition and drug use.**

14. **That the Nova Scotia Reproductive Care Program be expanded throughout the Province so that prenatals receive lifestyle risk assessment and appropriate follow-up counselling.**

15. **That greater emphasis be placed on health education and nutrition in the Departments of Education and Social Services, so that quality health related policies will be increasingly integrated into Government funded programs.**

16. **That the Government increase support to programs aimed at the prevention of alcohol and drug abuse, particularly among young Nova Scotians.**

17. **That prenatal nutrition counselling services be covered as an insured service under M.S.I.**

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5 Hospitals

Introduction

As noted in Chapter 2, thirty-four groups and/or individuals including physicians, hospital administrators, representatives of hospital boards, various health professionals, and ordinary citizens made seventy-five recommendations directly pertaining to hospitals. These recommendations addressed a broad range of issues including funding for additional services, new equipment, renovation of some hospitals, and total replacement of others. There were also recommendations concerning hospital policies and practices.

While many submissions called for more preventive and community-based services, and commented on the disproportionate costs of the "illness system" - of which hospitals are the largest part - there was almost no criticism of the hospital services themselves. This would appear to bear out the general belief, expressed by successive governments, that Nova Scotia has a hospital system of which we can be proud, and which provides a very high standard of care.

However, there was sufficient evidence placed before the Committee to make it clear that improvements should be made to the hospital system in Nova Scotia. The following sections of this chapter address issues such as: capital funding for hospitals; the provision of hospital beds, including target ratios for acute and extended care beds, and the geographic distribution of beds; flexibility and innovation in hospitals; and regional co-operation in the operation of hospitals in Nova Scotia.

The chapter concludes with fourteen (14) recommendations listed in the order in which the subject matter was presented in the text of the Chapter.

Capital Funding for Hospitals

Institutional Factors

Ownership of hospitals is an important factor with regard to capital funding for hospitals. Hospitals owned by the Provincial Government have hospital boards appointed solely by the Governor in Council, and construction for these hospitals is covered 100%, "up front", by Government.

In non-provincially owned hospitals, the Province funds construction projects on a 20/40/40 basis. The local community is responsible for 20% of all construction and planning costs. The Province makes a direct payment of 40% of all construction and planning costs. The hospital borrows the remaining 40% of funds, and the Department of Health pays the hospital Capital Debt Assistance over a long term period to cover the hospital's borrowing repayments, both capital and interest. However, it has not always been possible to follow this procedure and special grants have had to be made to some hospitals unable to raise the 20% local funding required under present policies. Although there are some exceptions, the "20% rule" prevents any hospital from building or renovating without the approval of the Department of Health.

In 1959 when hospital insurance came into being the Nova Scotia Government owned four hospitals - the Victoria General Hospital, the Nova Scotia Hospital, and the two Tuberculosis Sanitoria in Kentville and Point Edward. There are now forty-seven general hospitals and two psychiatric institutions in Nova Scotia. Of these, the Government of Nova Scotia owns seven general hospitals and one psychiatric hospital i.e. the Nova Scotia Hospital. The seven hospitals are in Halifax - The Victoria General Hospital; the Halifax Infirmary; Camp Hill Hospital and the N.S. Rehabilitation Centre - and in Cape Breton County - Sydney City Hospital; Northside Harbour View Hospital and Glace Bay Community Hospital. These seven hospitals account for 2,078 (40%) of the 5,137 non-psychiatric hospital beds in Nova Scotia.[1]

The procedure respecting purchase of equipment, the other aspect of capital funding, is as follows. All government owned hospitals buy equipment by the outright purchase method, i.e., where the cost is provided in one lump sum in the annual budget. Seventeen other hospitals are funded by this method and the remainder, 23, are funded by grants, whereby the hospitals buy the equipment from their own funds, and receive grants semi-annually, according to a depreciation schedule, to enable them to save up capital funds to replace the item when it wears out 10 or 15 years in the future. While the number of hospitals on each method of payment is similar, it is the larger hospitals that are on outright purchase, and account for more than 75% of the funds spent on equipment in any one year. Information regarding hospital ownership, beds, equipment purchase, and construction funding is summarized in Table 1.

The background material outlined above has important implications for capital funding for hospitals. Ten years ago, the Department of Health's construction budget covered 40% of most projects and the costs of 100% funded projects were less than 15% of the budget. Now, a high proportion of projects must be funded 100%, which effectively reduces the value of the capital funds in terms of the number of projects that can be undertaken. In 1982/83, 100% funded projects accounted for 58% of the construction budget. In 1983/84, committed projects accounted for 72% of the budget and these figures exclude the 100% financing of construction at the Victoria General and Nova Scotia Hospitals, which are covered in the budget of the Department of Government Services.

As noted above, the trend is towards increasing numbers of hospitals being owned by government, with five of the seven hospitals being taken over in the past ten years, three from religious orders and two from other levels of government. Hospitals are taken over by the government usually because the owners cannot afford the capital cost of renovation and re-equipping. Thus it is usually the case that such hospitals need renovation and new equipment, and hence use large amounts of construction funds. This has not been recognized in budget allocations.

In summary, there has been an increased dependence on government for capital funding for hospitals during the past decade. This has been due in part to the takeover of some hospitals by the Provincial Government (hence requiring 100% capital funding) and in part because more non-provincially owned hospitals have required special grants for capital funding. Finally, increased pressure on government funding has also arisen because hospitals taken over by the government are usually in need of renovation and re-equipping.

Table 1

	Institutions by Group	Beds	Ownership	Equip. Outright Purchase	100% Construction
Small Community	Annapolis General	26	Lay	X	
	Bayview Memorial	13	Lay	X	
	Buchanan Memorial	13	Lay		
	Eastern Kings	28	Lay		
	Eastern Shore Memorial	35	Lay	X	
	Eastern Memorial	15	Lay	X	
	Guysborough Memorial	17	Lay		
	Lillian Fraser	29	Lay		
	Musquodoboit Valley	12	Lay		
	North Cumberland	11	Mun./Lay		
	St. Anne	—	Lay		
	St. Mary's Memorial	15	Lay	X	
	South Cumberland	16	Mun./Lay		
	Sutherland-Harris	58	Mun./Lay		
	Twin Oaks Memorial	25	Lay	X	
	Victoria County	23	Lay	X	
	Sub Total	**336**			
Medium Community	All Saints	62	Lay		
	Digby General	88	Lay		
	Fishermen's Memorial	60	Lay		
	Hants Community	120	Mun.		
	Inverness Consolidated	75	Lay	X	
	New Waterford Consolidated	88	Mun.		
	Queens General	55	Lay		
	Roseway	56	Lay	X	
	Sacred Heart	40	Rel.	X	
	Strait-Richmond	24	Lay	X	
	Western Kings Memorial	76	Lay		
	Sub Total	**744**			
Large Community	Dartmouth General	114	Lay		
	Glace Bay Community	140	PG/Lay	X	X
	Glace Bay General	112	Lay		
	Northside Harbour View	197	PG/Lay	X	X
	Soldiers' Memorial	74	Lay	X	
	Sub Total	**637**			
Regional Hospitals	Aberdeen	201	Mun.	X	
	Colchester	184	Mun.		
	Dawson Memorial	76	Mun.		
	Highland View	103	Mun.		
	Valley Health Services	170	Lay		X
	St. Martha's	171	Rel.	X	
	St. Rita	140	Rel./Lay	X	
	Sydney City	157	PG/Lay	X	X
	Yarmouth Regional	156	Mun.		
	Sub Total	**1,358**			
Referral and Specialty	Camp Hill 355	160 Chronic 195 Acute	PG/Lay	X	X
	Grace Maternity	126	Rel.	X	
	Halifax Civic	50	Mun.	X	
	Halifax Infirmary	381	PG/Lay	X	X
	Izaak Walton Killam	302	Lay		
	Victoria General	796	PG	X	X
	N.S. Rehabilitation Centre	52 (Type IV)	PG/Lay	X	X
	N.S. Hearing & Speech	None	Lay		
	N.S. Cancer Treatment	None	PG/Lay		X
	Point Pleasant Lodge	—	Lay		
	Sub Total	**2,062**			
Psychiatric	Cape Breton Hospital	62	Mun.	X	X
	Nova Scotia Hospital	395	PG	X	X
	Atlantic Child Guidance	—			
	Metro Mental Health Plan	—			
	Sub Total	**457**			
	Grand Total	**5,594**			

PG - Provincial Government Rel. - Religious Mun. - Municipal

Technical Considerations

The previous section dealt with some of the institutional factors impacting upon capital funding for hospitals. This section addresses the procedures, and some of the technical considerations involved in deciding whether or not renovations or construction of hospital projects should proceed.

In simple terms there should only be two reasons for renovating or constructing a hospital:

(1) The hospital fabric has worn out. That is, the systems or structure of the hospital have reached the point where they are breaking down or collapsing;

(2) The work being done by the hospital is changing and/or expanding, and the hospital structure and systems cannot cope with the new requirements.

In Nova Scotia both factors are usually involved, but the second is the driving force. An example of the first type is the renovations to New Waterford Consolidated Hospital, where the outer shell and structural steel were inadequate to last beyond 20 years. A clear example of the second is the expansion to Dartmouth General Hospital to accommodate a growing caseload. Examples of mixed type projects would include most other recent major projects including those at Aberdeen Hospital, New Glasgow; Northside Harbour View Hospital in North Sydney and Sydney Mines. The expansion at the Victoria General Hospital, i.e., the Ambulatory Care Centre, is another example.

Although the two reasons for hospital renovation or reconstruction projects appear straightforward, in both cases the need is rarely absolute. That is, if the project is not undertaken the hospital will not cease to operate, nor will lives be endangered (in the short term) if the work is not done. Nearly all buildings can be patched up, added to, or operated tolerably in spite of major space or structural problems. To ascertain the validity and the priority, in terms of timing, of requests for renovation and/or reconstruction funds the following factors are considered. These factors apply to projects over $100,000 since smaller projects are usually minor renovations with no major consequences to the hospitals' operation.

Requests, which are almost always initiated by hospitals, are either for building and system repairs or for more space. Requests for building and system repairs are reviewed according to the problem expressed, the age of the building and its systems, the use made of the area/system in question, and comparison with published standards - building or fire codes, or health facility design guidelines. Such projects might include window replacement; medical gas system upgrading; fire protection systems - sprinklers, detection systems, etc.; brick work or roof repairs; heating system replacement, etc. Often a consultant's report is requested, as few hospitals can assess the status of these systems in any depth. Once reviewed, the project is approved in principle if it is felt to be necessary, or rejected if it is deemed to be unnecessary. Final approval of a grant will depend on the relative priority of the project compared to other projects and the capital funds available. High priority is given to items affecting patient care and safety - fire, medical gas system projects, but this is tempered by consideration of the probability of a problem solution arising, and, where possible, a simpler, cheaper, or partial solution may be suggested.

The majority of costly project requests are for more space, usually for expanding services and increased workloads. The requests are often for increases in size because many spaces or systems that are quite sufficient for the present operation are affected by new plans, and "they might as well be changed/renewed while we're at it". The process of consideration in these projects is more complicated. To consider such requests requires the following steps, many of which must be repeated and require prolonged negotiation:

1. What is the hospital's medium and long term role or mission, and how does this relate to the roles/missions of neighbouring and referral hospitals?
2. What is the need for the proposed services, what population will be served, and what volume of patients is expected?
3. What are the time trends for diseases/diagnoses and utilization over the past and future 5 to 10 year periods, and how do they compare with other similar populations and/or institutions and services?
4. What is the relationship of proposed service to other hospital services - clinical, diagnostic/therapeutic and supportive?
5. What are the manpower consequences (physicians, nurses, etc.) and equipment and service requirements (e.g., medical gases, power supply, etc.)?

When the factors outlined above have been satisfactorily determined, the needed space, services, staff, and equipment can be calculated. This is followed by the process of building and systems assessment, to determine how much of the required space can be obtained by renovation, and how much needs to be new construction. The consequences of such decisions must be acceptable to the Fire Marshall and other standards and regulatory bodies.

Once the above steps have been followed, the final task is to assign priority to major projects. To properly assign priorities to such projects a coherent program of upgrading and expansion of services is required. In the absence of such a long term plan, decisions such as whether a new outpatient department is more important than a nuclear medicine unit; or a new x-ray/diagnostic imaging department is less vital than an expansion of operating rooms may be made on an ad hoc basis.

Capital Funding for Hospitals: Requirements for the Future

As a result of various submissions made to the Select Committee, and visits made to various hospitals around the Province, the Committee believes that some major capital expenditure on hospitals is necessary.

The increased dependence on government funding of capital projects for hospitals, even those institutions which have reserves of capital, has placed a special responsibility on government to provide stable commitments for major projects over a period of years.

The requirement for stable, longer term funding commitments is also suggested by the complexity of planning construction projects. The planning and construction of a regional hospital of around 200 beds will take five years from start to finish, if all goes well. Uncertainties over funding from year to year delay the planning to the point that personnel change, and plans require major revision. Local support, raised in expectation of tangible results in the near future, fades away as projects are slowed down, and is difficult to enlist again. A further problem arises when major projects are delayed because interim decisions on necessary renovations and equipment may be made in ignorance of the longer term outcomes.

Hospital construction expenditures made by the Provincial Government over the past twelve years and estimated for 1984-85 are shown in Table 2. A very rough guide to the cost of hospitals is approximately $100,000 to $125,000 per bed. Given the 5594 hospital beds in Nova Scotia, the total replacement cost would be between $560 million and $700 million. An industrial capital replacement rate would be in the range of 5% to 10% per annum. Obviously hospitals in Nova Scotia (or elsewhere in Canada) have not been on this type of schedule. A 5% capital replacement rate for Nova Scotia would result in a capital budget for hospitals of $28 to $35 million per annum - a 10% replacement rate would be in the range of $56 to $70 million. While the Select Committee has not recommended the exact amount that should be allocated in the Provincial Budget for capital expenditures on hospital projects, it is obvious from the information presented that the amounts must be increased, and must be provided on a longer term basis to permit adequate planning.

Table 2
Hospital Construction Expenditures

	Dept. of Health Construction Grants	Capital Debt Assistance	Dept. of Government Services
	Actual $	Actual $	Actual $
1972-73	933,665	1,499,295	1,857,975
73-74	1,164,770	621,508	665,975
74-75	5,284,865	1,119,207	185,739
75-76	10,096,115	1,153,271	3,368,067
76-77	4,295,460	1,628,047	5,276,012
77-78	1,448,272	2,744,144	5,866,848
78-79	3,249,598	4,124,752	4,381,473
79-80	2,904,141	3,106,365	1,826,088
80-81	10,722,777	2,807,317	2,871,087
81-82	10,975,096	3,475,290	23,645,053
82-83	9,934,615	4,199,034	12,178,361
83-84	5,647,100 (F)	4,810,500 (F)	7,262,000 (F)
84-85	9,500,000 (E)	4,778,100 (E)	9,835,000 (E)

N.B. These refer to government expenditures. The cost of projects is greater, due to the local share (20%).

E = Estimate
F = Forecast

Source: Department of Health

The Provision of Hospital Beds

The Select Committee on Health received submissions recommending against bed closures, recommending bed closures, and recommending expansion of beds. The provision of hospital beds is a difficult issue, and has been addressed over the years by a number of bodies examining health care in Nova Scotia. For example, in 1972 the Report of the Nova Scotia Council of Health contained the following recommendation regarding the provision of active treatment beds per 1,000 population in Nova Scotia:

> "The Health Council recommends that a goal of 4.5 beds/1,000 (25% reduction on present levels of about 6.0 beds/1,000) should be used as a goal for active treatment facilities to be achieved as alternative methods of care, such as improved home care and ambulatory care are developed. 4.0 beds/1,000 should be anticipated as a future goal. This objective is an average for the province and should be reassessed annually."[3]

The Report went on to state that "achievement of these objectives will establish new emphasis for our treatment resources. We must develop new approaches to care, including home care programs, ambulatory care, the use of nursing homes instead of hospitals, and increased emphasis on self care as well as improved evaluative standards, and methods of assessing performance and effectiveness."[4]

The situation regarding hospital beds has not changed dramatically since the Council of Health's Report twelve years ago. At present, the provision of hospital beds in Nova Scotia is slightly below the Canadian average (6.3/1,000 - N.S.; 6.5/1,000 Canada). However, the provision of **acute** hospital beds (6.1/1,000) is one-third higher than the Canadian figure, (4.5/1,000) while extended care beds (0.2/1,000) are less than one-seventh of the national average (1.5/1,000). In other words, while the total beds are adequate, the distribution by type of bed is quite different from much of the rest of Canada. The fact that the distribution of beds by type is different in Nova Scotia compared to the Canadian average is not necessarily "bad", and overall the service provided by Nova Scotian hospitals has been most satisfactory. However, it is nonetheless the case that some provision of formal units for longer term care (Type III) is desirable for those patients who cannot be cared for in a Nursing Home.

The assertion that a bed ratio by type for Nova Scotia, the same as the Canadian average, may not be a desirable goal, is based on a number of factors. First, considering the absence of alternatives it does not appear that the number of long term patients in hospitals in Nova Scotia is "inordinately" high. For example, only 65 patients are currently (March 1984) reported on the Department of Health's Monthly Long Stay Reports as having been in hospital for over 180 days. Another measure shows that on average just over 200 patients leave hospital each year with a length of stay over 180 days. This represents less than 0.15% of total separations of about 155,000 per annum. Stays over 180 days account for 6.7% of patient days. Further, stays over 30 days account for 4.7% of separations and 27% of patient days. For more detail, see Table.3

Second, it is generally acknowledged that Canada's record for institutionalizing its elderly (whether in hospital or in Homes for Special Care) is much higher than in most other countries with well-developed nationally funded health care systems. For example, days in hospital/1,000 population over 65 years of age was 8,242 in Canada (1977), 5,858 in Nova Scotia (1981-82), and 3,955 in the U.S. that year. This is an expensive practice to follow as the number of elderly Nova Scotians continues to grow. For example, the per diem cost of a patient in an extended care hosptial was $109 (Canadian average, 1982-83) versus $254 for an acute care (non-teaching) hospital. Nova Scotia has no extended care hospitals, but the mean acute hospital per diem was $250. The per diem cost of a patient in a Home for Special Care in 1982-83 ranged from a low of approximately $11.50 to a high of $91.10 depending upon the level of care provided. Obviously it is desirable to find appropriate, less expensive alternatives to institutionalization, and Chapter 6 on Home Care addresses this issue.

For the above reasons, the Select Committee on Health felt that planning for extended care hospital beds should not aim at a target rate per thousand equivalent to that of Canada. A smaller number of beds should be provided as formal extended care units, with other hospital beds, especially in the smaller, rural institutions, used on a needs basis as required, without formal designation.

Table 3
1975-1981/82
Separations and Days/1,000 Population for Residents of N.S. (excluding Newborns) by Age Group

Separations/1,000 Population

Age Group	1975	1976	1977	1978	1979/80	1980/81	1981/82
0-14	117.6	115.4	115.6	116.9	113.6	106.6	103.1
15-44	143.2	142.1	143.1	141.4	135.0	129.1	131.8
45-64	181.9	184.0	194.7	193.3	189.1	188.0	189.2
65-69	253.5	268.4	290.1	293.0	296.6	307.5	302.2
70-74	306.2	314.7	338.0	343.6	356.8	377.5	377.3
75+	405.8	425.4	447.0	457.9	471.5	487.5	491.9
Total	**160.0**	**162.2**	**167.3**	**167.8**	**164.6**	**162.0**	**164.2**

Days/1,000 Population

Age Group	1975	1976	1977	1978	1979/80	1980/81	1981/82
0-14	737.6	717.6	684.9	683.9	652.7	598.5	571.8
15-44	1030.3	987.6	979.9	957.0	907.5	853.4	867.6
45-64	2303.9	2292.0	2360.4	2338.9	2180.0	2126.5	2071.6
65-69	3847.1	4090.4	4128.1	4169.2	4125.6	4270.0	3961.8
70-74	4938.0	4982.1	5084.8	5300.1	5365.2	5430.4	5327.6
75+	7145.3	7442.6	7344.2	7759.9	7789.1	8069.3	8068.0
Total	**1602.5**	**1610.0**	**1618.9**	**1635.1**	**1583.6**	**1559.9**	**1566.3**

Source: Cases and Days by Age Group Run, Department of Health Population Estimates, 1981 Census Statistics Canada Publication E561

In terms of overall bed ratios the recommendations of the N.S. Council of Health in 1972 are appropriate as general guidelines **but** only if more extensive services, such as a home care program, are made available outside the hospitals. This "quid pro quo" is necessary or the dislocation involved in moving from a total bed base of 6.3/1,000 to 4.5/1.000 would obviously be too great.

Geographic Distribution of Hospital Beds

Hospital beds in Nova Scotia are not only maldistributed by Type (Acute/Rehabilitation/Extended Care) but also by geography. The location of hospital beds in the province follows pre-universal insurance patterns, mirroring the industry and/or wealth of the local communities and institutions in the first half of the 20th Century rather than present day population needs.

For example, there are large numbers of hospital beds and patterns of high utilization from Cumberland County through the New Glasgow townships to the industrial area of Cape Breton. The latter is the most extreme example of this legacy, with beds per 1,000 population rising in some local areas[2] to over 8 compared with a provincial average of about 6. This comparison is made more disparate since the provincial figure includes all hospital beds including tertiary care beds, whereas the former does not. A more valid comparison is between 8 beds/1,000 for primary and a few secondary services, versus a provincial figure of around 4/1,000. Another example is the Annapolis Valley where high bed provision is due to a relatively prosperous string of communities stretching from Digby to Windsor. Information on the distribution of hospital beds per 1,000 population by region and utilization by region is given in Table 4.

This geographic maldistribution has proven very resistant to change. In 25 years of universal insured hospital services, hospital beds have increased in parallel with the increasing population, but the geographic inequities have not altered. In dollar terms this means that more is being spent on the health care services for the residents of some parts of the Province than on others.

To some extent this inequity is unavoidable as expensive services are regionalized in relatively few areas, such as tertiary services in Halifax, but to a great extent the inequitable distribution is due to continuance of outdated historical patterns.

Obviously it would be unnecessary and wasteful to try to obtain an equitable distribution of beds by increasing the less well provided areas to match the levels of the over-bedded localities. No measurable health benefit would result. On the other hand, rapid closure of beds, with the consequent need to alter patterns of practice and utilization and loss of jobs, would also be undesirable. However, a deliberate policy of providing no additional beds in the communities with a high supply, and encouragement to divert the resources that would have been spent on extra beds into more appropriate programs such as community outreach services should be pursued. This would serve the twin objectives of reducing unnecessary hospital utilization, and providing more extensive health services, while preserving employment. Incentives, such as grants to convert acute care beds to ambulatory care or extended care, for example, could speed up the desired change.

Table 4 Nova Scotia

	Hospital Beds per 1,000 Population by Region			Utilization of Hospital Beds, By Region, By Place of Hospitalization					
				Separation/1,000 Popn.			Day/1,000 Popn.		
	Beds Open & Operating	Popn. (1982 est.)	Acute & Ext. Care Beds/1,000	Local	Hfx.	Total	Local	Hfx.	Total
Region I Lunenburg Co. (Except Chester Mun.) & Queens Co.	191	48,935	3.9	99	46	145	787	524	1311
Region II Shelburne/Ymth/Digby Counties	300	65,533	4.6	126	29	155	1254	361	1615
Region III Annapolis & Kings	374	72,503	5.2	157	30	187	1209	347	1556
Region IV Colchester County + 20% of Hants County	213	50,041	4.3	134	39	173	1067	479	1546
Region V Cumberland County	205	35,139	5.8	192	40	232	1490	482	1972
Region VI Pictou County	259	50,590	5.1	156	33	189	1530	395	1925
Region VII Antigonish, Guysborough Inverness & Richmond Counties	357	65,786	5.4	179	31	210	1483	390	1873
Region VIII Victoria & Cape Breton Counties	870	135,709	6.4	175	21	196	1710	264	1974
Region IX Hfx. County + 80% of Hants Co. & Chester Mun.	2368	327,258	6.4[1]	30	97	127	266	952	1218
	5137	**851,494**	**6.0**			**163**			**1545**

[1] Utilization of Hospital beds by Hfx. Co. & Hants Co. residents gives a bed/1,000 rate of around 3.9/1,000 population. 1981/82 figures are used for Local/Hfx. split. 1982/83 figures are used for total utilization figures.

Source: N.S. Dept. of Health A/S System.

Flexibility and Co-operation

Flexibility is an important characteristic of health care delivery systems. Health requirements change over time, and constraints both financial and otherwise, are encountered. Hospitals are a key component of the health care system, and they should be given the flexibility to be responsive and innovative as health care evolves to meet different challenges. Some issues involving flexibility, innovation, and co-operation are discussed below.

Hospital Service

When universal government-funded health insurance was introduced in 1959, the agreement with the Federal Government required that services be delivered in hospitals, if they were to be insured. While this is no longer the case since Established Programs Financing (EPF) was established in 1977, the Provincial Act (Hospital Regulations under H.S.I. Act) still refers to **hospital** insurance. This has acted to a great extent as a barrier to the insurance of non-hospital services, such as home nursing care, home oxygen, community occupational therapy and physiotherapy, day hospital programs, etc. On the other hand, insurance of programs delivered through hospitals has given greater control than has been the case in provinces where physicians (or private companies) have run independent laboratories, x-ray services and the like.

It would be an important aid to flexibility of health care delivery if the Act and Regulations were amended to allow hospitals to deliver a broader range of services, operating from or through, but not necessarily in the institutions. Obviously this approach must be co-ordinated with the development of a home care program in Nova Scotia and be compatible with the role of the community health services, both government and voluntary/private. Such a recognition of the potentially broader role of hospitals would encourage boards and staff to consider health problems as a whole, and to tackle them more efficiently and effectively on a program basis, not delimited artificially by hospital service boundaries.

Another aid to flexibility and innovation in hospital services could be to allow hospitals providing services efficiently to retain unspent portions of their budgets. This would require agreement on the nature, level and quality of services the hospital was required to provide, and safeguards would be needed on the possible range of uses to which any such retained monies could be put, but it would provide an incentive to operate economically, to try new approaches, an aspect missing from the present system.

A particular example of an unmet need as far as hospital services are concerned, is that of acute, short-term rehabilitation. These services, if available readily and used properly, can cut down time off work and reduce future chronic disability. Such service may be hospital-based and work with inpatients, but can also provide, in appropriate industrial locations, ambulatory, outreach and preventive programs.

The specific needs are for physiatrists, occupational therapists, and physiotherapists, to provide services in areas outside Halifax, and this will involve the reuse of current acute beds for rehabilitation purposes. The training of occupational therapists at the School at Dalhousie University will also be a boon if departments can be established in regional hospitals.

Co-operation and Regional Planning

A significant obstacle to change is the very local focus of most hospital boards. Almost no multi-institutional or regional planning currently takes place except when the services involved are add-on, and relatively marginal in effect. Regional planning would help eliminate the duplication of multi-hospital services and programs. Obviously some mechanism to encourage co-operation at a regional level would be desirable.

One mechanism or model, which is used in Ontario, is that of District Health Councils. These Councils have a small staff, and no direct financial authority. However, any requests for new services, equipment or construction must be approved by the Council before the Ontario Ministry of Health will consider approving it. This model is not suitable for all of Nova Scotia, but should be considered for the Halifax Metro area and Industrial Cape Breton.

Another mechanism is that of cross-representation on hospital boards. This could entail a couple of seats on the regional hospital board for community hospital board members, or for regional hospital board members on tertiary hospital boards. This arrangement would be beneficial to both parties, allowing communication and involvement with voting power.

At the medical level, partial payment for chiefs-of-staff at regional hospitals to provide advice on request to community hospitals, and perhaps to chair a regional Standards Committee - as permitted and proposed in the Hospital Regulations under the Health Services Insurance Act - might prove beneficial.

Whatever mechanism is chosen, it should recognize that inter-institutional co-operation is essential, when transport is fast and easy, and specialty services are increasingly going to be provided only in larger centres. One step towards this would be the requirement for hospitals to prepare and submit to the Department of Health physician manpower plans for 3 to 5 years ahead. In this way, duplication of services might be avoided, and regional planning for specialist acquisition would be encouraged.

Recommendations

The Select Committee on Health Recommends:

1. **That the government, after close consideration of the needs for new hospital construction and the priorities thereof, and a realistic estimate of the resources required to meet those needs, agree to provide appropriate capital funds in an orderly fashion, on a five year basis.**

2. The Select Committee on Health did not attempt to undertake the type of detailed analysis that would result in a complete priorized list of construction projects. However, with regard to major projects the Committee makes the following recommendation:

That the following projects should be high on the Government's list of necessary renovations and replacements: the Grace Maternity Hospital; St. Martha's Hospital; Cape Breton Regional Hospital; and the Halifax Infirmary.

3. That government pursue a target of 5.0 acute care hospital beds per 1,000 population in conjunction with the introduction of more extensive services, such as a co-ordinated home care program outside of hospitals.

4. That extended care (Type III) beds be established in Nova Scotia with an initial overall target of 1/1,000 population.

5. That in areas with a higher than average supply of beds, taking into account the levels of service offered (community/regional/tertiary) new acute care beds be added.

6. That in areas with significantly fewer than average beds/1,000 population, additional beds should only be considered for extended care (Type III), except in rare instances, such as Bridgewater, where acute care beds may be warranted.

7. That hospitals in such regions as the Valley, Cumberland, Pictou, Inverness, Cape Breton County, and Lunenburg should be encouraged to convert, where possible, and necessary, acute beds to extended care beds or to ambulatory care services.

8. That the Government provide incentives, such as 100% renovation grants, to encourage necessary changeovers from acute care beds to extended care or ambulatory care services.

9. That the Provincial Hospital Insurance Act be amended to allow hospitals to deliver a broader range of services, operating through but not necessarily in the institutions.

10. That hospitals which provide services efficiently should be allowed to retain unspent portions of their budgets, to encourage flexibility and innovation.

11. That short-term rehabilitation services be developed in Nova Scotia, and that appropriate numbers of physiatrists, physiotherapists, and occupational therapists be employed to provide this service.

12. That the Provincial Government develop a mechanism to encourage co-operation and multi-institutional planning among hospitals at the regional level.

13. That hospitals be required to submit five year physician manpower plans to the Department of Health on an annual basis.

Footnotes - Chapter 5

1. The Miller Hospital in Kentville is still owned by the Province, but is operated, along with the Blanchard-Fraser Hospital, and the Division of Mental Health Services, by Valley Health Services Association.

2. The use of beds/1,000 population is misleading on a local basis, as no localities except Halifax have all levels of hospital care available locally. Thus, a city such as Sydney has many beds relative to the local population, but many fewer if the regional role of the hospitals is taken into account.

3. **Health Care in Nova Scotia**, "A New Direction For The Seventies", The Report of the Nova Scotia Council of Health, page 21.

4. Ibid., page 21.

6 Home Care

Introduction

More recommendations were made to the Select Committee regarding the development of a home care program in Nova Scotia than for any other specific type of program. Nineteen groups and individuals made twenty-nine recommendations on the subject of home care. Health professional groups, the VON, homemaker organizations, organizations of the disabled, church groups, social service agencies, hospitals, universities, and consumer organizations were sponsors of recommendations dealing with home care.

It is hardly surprising that a broad range of organizations recommended the implementation of a home care program in Nova Scotia. During the past twenty years there has been increasing interest in home care by health planners, and home care programs of various types are already in place in other provinces.

The interest expressed in home care by health care planners, and the introduction of home care programs in other provinces have been motivated by a number of factors. One of the most important reasons is that institutionalized health care is relatively expensive. The search for alternatives leads to the realization that high quality health care can be provided to the patient at home, and often this can be accomplished through the co-ordination of existing services. There is some evidence to show that unnecessary hospital admissions can be prevented by providing home care.[1] There is also reason to believe that demands for institutional expansion can be moderated through earlier discharge of patients from hospital to a home care program although this is more difficult to verify.

In essence, the arguments for a home care program are that it has the potential to provide a more appropriate setting for health care for some patients and home care can be more cost-effective than institutional care.[2] Home care can also have the additional benefit of providing skills to families that better enable them to care for family members, who are ill, in their own home.

Since the term "co-ordinated home care" is used throughout this Chapter it is important to provide a definition. For the purposes of this discussion, co-ordinated home care is defined as an alternative to hospital and other institutional care, whereby medical services, social services, and the services of health related personnel, together with the resources of appropriate agencies, combine to function as a team for the maximum benefit and support of the individual treated at home.

The term co-ordinated home care as defined above assumes that the home care program is comprehensive. Although comprehensiveness can vary in degree, as will be seen in the following discussion, the core services provided to ensure comprehensiveness include homemaking, nursing, occupational therapy, physiotherapy and medical services. Co-ordination assumes that the resources of a number of health and social services are provided to effectively meet the needs of the patient, and that the home care program is integrated into the existing health and social service system to assure maximum benefit and efficiency.

This Chapter reviews home care programs currently operating in other provinces, and examines evidence on the important but complex issue of the cost effectiveness of home care. A short section is also included on the connection between the age structure of the population and home care. The last section outlines some important factors that should be considered in the development of a home care program in Nova Scotia. This Chapter concludes with the Committee's recommendations on home care.

Home Care Programs in Canada

This section contains a brief summary, by province, of the major aspects of home care programs in Canada.[3] Although service levels, components, and the organizational structure of the existing programs vary somewhat from province to province, there are many common elements among these programs.

Nova Scotia

Co-ordinated home care programs are more complete in other provinces than in Nova Scotia. Although this province does not have a co-ordinated home care program, there are a number of existing services that do provide elements of such a program. For instance, homemaker services are provided through voluntary agencies and municipal units under the sponsorship of the Provincial Department of Social Services. Some home nursing services are provided by provincial public health nurses, and the VON provides home nursing in 12 areas of the province. In addition to this, two home care pilot projects are operating in Pictou and Lunenburg counties. There is also a Senior Citizens' Assistance Program through which senior citizens with incomes of less than $12,000 per year are eligible for a $3,000 forgiveness loan to be used for home repairs that would enable them to remain in their own homes. Finally, the Department of Social Services has recently announced an expansion of the Home Life Supports Program intended to assist seniors and the disabled to remain in their own homes and communities. Services intended for inclusion in this program are homemaking, daycare, respite care, meals on wheels, home nursing and home handyman.

However, even with the services outlined above, home care in Nova Scotia is neither comprehensive nor co-ordinated, and some individuals simply do not have access to many of these services.

British Columbia

Home care services in British Columbia are provided through three programs, all of which are sponsored by the Ministry of Health. These programs are the Long Term Care Program, the Home Nursing Care Program, and the Community Care Program. The combined resources of these programs provide a range of services including home nursing, geriatric day care, physiotherapy, occupational therapy, meals on wheels, and homemaker services. Care is provided to both chronic and acute care patients. In terms of coverage, not all services are available in all parts of the province, and fees are required for some services depending on the income of the client. Home care programs are administered by either Provincial Health Units or Municipal Boards of Health.

Alberta

The Alberta Co-ordinated Home Care Program is sponsored by the Department of Social Services and Community Health. Core services include home nursing and homemaker services. Additional services including physiotherapy, speech therapy, occupational therapy, and respiratory therapy, dressings, drugs, meals on wheels, and transportation services may also be provided. Care is provided to those persons requiring at least one "medical" (e.g., home nursing or respiratory therapy) service delivered in the home. All treatments provided by the Home Care Program are under the direction of the individual's personal physician.

Medical services are provided without charge. Other support services are provided free to clients during the first two weeks of the use of the program. Fees are charged after this period based on family income. The program is administered by local health authorities or staff of agencies which are contracted to provide service.

Saskatchewan

The Saskatchewan Home Care Program is provided through the Department of Social Services. Primary home care services are nursing, homemaking, meal provision, and home maintenance. These four services are provided throughout the Province while additional services are provided as funding permits and needs dictate. A person does not necessarily need a physician referral or a "health care" service to qualify for the program, and there is no limit on the length of time for which eligible persons can receive service.

There is no charge for nursing services although a client may have to pay a charge for other services depending on the level of family income. The program is operated by forty-five (45) locally chosen district home care boards.

Manitoba

In Manitoba the Department of Health is responsible for planning, standards, and resource allocation of the Provincial Home Care Program, while the Department of Community Services and Corrections is responsible for service delivery and budget. Services cover a range of health treatment, personal care, therapy, home support, health promotion, and volunteer services as well as social services and supplies as required to maintain a person in the home environment. Any person who is at risk of having to be hospitalized or placed in a nursing home or other care facility is eligible for the program.

There is no charge for the service provided by the program except meals on wheels. The program is administered by the Office of Continuing Care, and is delivered by the Department's regional and local staff or an external agency's staff.

Ontario

Acute and chronic home care needs are met through a Home Care Program sponsored by the Ministry of Health in Ontario. In addition to this the Ministry of Community and Social Services sponsors a Home Support Program for the Elderly and a Visiting

Homemaker and Nurses Service. These programs provide a range of home care services including nursing, physiotherapy, occupational and speech therapy, drugs and medical supplies, nutrition counselling, social work services and homemaker care. The acute and chronic home care requirements of a person under the medical supervision of an attending physician are covered as an OHIP benefit. Charges are levied for other services depending on family income.

Home care services in Ontario are administered through a variety of mechanisms including local Public Health Units, Regional Boards of Health, voluntary boards, hospital boards and one incorporated organization dealing exclusively with home care services.

The Home Care Program for Metropolitan Toronto delivers home care services through the utilization of existing community services. This program is funded by the Ministry of Health, and operated by a community health service agency which is a non-profit corporation devoted to the provision of a planned, co-ordinated treatment program to patients in their own homes. The home care program employs its own staff mainly for administrative and co-ordination purposes and purchases services from a wide variety of community agencies and other providers of health care. Nursing services, for instance, are purchased from the Victorian Order of Nurses and the Saint Elizabeth Nurses Association. Homemaker services are purchased at negotiated rates from a number of voluntary and commercial agencies. The assessment of patients referred to the program and the co-ordination of services is accomplished by Home Care program staff who are located in hospitals, clinics or the central office.

Quebec

In Quebec, home care services are sponsored by the Department of Social Affairs and organized by the Regional Health and Social Service Councils. As in other provinces the services provided include nursing, homemaker, physiotherapy, occupational and speech therapy, nutrition counselling, and meals on wheels. Where possible services are delivered or co-ordinated by local community centres.

Home care is available to all persons who can be treated at home and who, due to their physical, psychological or financial situation, are unable to meet their own personal and material needs and are incapable of getting out to receive care in a health facility. There are no charges for home care services in Quebec, except for meals.

New Brunswick

New Brunswick provides home care services through a Home Care Program sponsored by the Department of Health and Social Services and the Extra-Mural Hospital program sponsored by the Department of Health. The Home Care Program provides care to both acute and chronic patients. Acute services include home nursing, physiotherapy, nutrition counselling, medications, and homemaking for relatively short (30 days) periods of time. A physician referral is required for acute care services. Chronic services consist primarily of homemaker services and other personal support services required for the individual to remain in the home. The Home Care Program is only available in the larger urban areas of the province. VON nursing services are utilized where possible.

The Extra-Mural Hospital program which is incorporated as a hospital is established in three areas of the province. A full range of acute care services are provided by this program which requires a physician referral.

There are no fees for the services delivered by these programs.

Prince Edward Island

Home care services in Prince Edward Island are provided through programs sponsored by the Department of Health, and the Department of Social Services. Core services include home nursing, homemakers, and occupational therapy. Other services including nutrition counselling, physiotherapy, and speech therapy are provided on a consultative basis to home nursing staff. Health services are provided without charge to anyone requiring care who is under the supervision of a physician, and homemaker services are provided to anyone in need. Fees are charged on the basis of family income for homemaker services.

The program is delivered by the Department of Health and the Department of Social Services.

Newfoundland

Newfoundland provides home care services through programs sponsored by the Department of Health and the Department of Social Services. In the St. John's area services are delivered by a voluntary agency which provides acute care consisting of home nursing, physiotherapy, occupational therapy, social work, laboratory, and homemaker services. Acute care patients require the referral of a physician. Supportive services, consisting primarily of homemaker services, are provided by this agency to senior citizens (in receipt of the Guaranteed Income Supplement).

Athough St. John's has the best developed home care services, some other areas in the province are served by home care programs which operate out of local hospitals. These programs primarily serve chronic patients and deliver nursing and homemaker services.

There are no fees charged for these services.

Summary

From the preceding discussion it can be seen that co-ordinated home care programs have developed different characteristics in each province. The core components of the programs are home nursing, occupational therapy, physiotherapy, and homemaker services. Additional services vary with the objectives of the programs; for example, whether or not the program is geared to meet the needs of acute or chronic patients, the elderly, or anyone that may require support to function in the home environment. Additional services include speech therapy and laboratory services, meals on wheels, handyman service, errand service and snow removal.

Home care programs are administered by the Provincial Departments of Health and/or Social Services. It is clear that close co-operation is required between these two departments. Services can be delivered by provincial government departments, municipal units, or voluntary non-government organizations.

Eligibility for services varies. Some provinces allow anyone to make referrals to home care programs while others require a physician referral to gain access to the program. Fees are charged for services in some programs, but all jurisdictions have income guidelines so that low income families, or individuals, can receive service at little or no cost.

It appears then, that the actual delivery of home care services can be accomplished in a variety of ways. However, whatever organizational model is selected for a home care program, there are several characteristics which are important for its effective operation. These include:

1. Staffing should consist of a multi-disciplinary team which can deliver a broad range of services and have firm connections with the full spectrum of health and social services.

2. Co-ordination of the services provided and good communication between the referring agency or individual and the home care program is essential.

3. As well as nursing, occupational therapy, physiotherapy, and homemaker involvement in the provision of co-ordinated home care, the participation of physicians is also important. Physicians should be part of the multi-disciplinary team either as staff members or as consultants. Contact with referring physicians, through regular case conferencing or some other means, needs to be maintained so that relevant information on the patient and emergency consultation is always available for home care clients with medical problems.

Home Care and Cost Effectiveness

One of the chief concerns of policy makers regarding home care is the cost of the program and particularly its potential to reduce health care expenditures. This section examines the costs of home care compared to hospital care, the effects of home care on hospital admissions and discharges, and the effect of home care programs on total expenditures in the health care system.

A striking example of the lower costs associated with home care programs is provided in **The Manitoba/Canada Home Care Study** (1982), produced by Health and Welfare Canada. The study compared costs of 1,167 persons in a home care program and the costs of caring for these same individuals if they were to be cared for in a designated alternative level of placement ranging from a nursing home to an acute care hospital. The study noted that:

> "The total cost of providing home care for the 1,167 persons in the study for the first month was $188,000. If each of these clients had instead been placed in their designated alternative level of placement, the total cost of providing care for one month would have been $1,382,000."[4]

Lawrence Nestman and Kyung Bay, Associate Professors in the Division of Health Services Administration, Faculty of Medicine, at the University of Alberta conducted an evaluation of the Edmonton Home Care Program from 1973 to 1976. As part of their research they reviewed many of the studies which compared the costs for home care with the costs of hospitalization. Most of these studies were treatment specific.[5] For example, costs of treatment for hysterectomy and herniorrhaphy patients in both modes of care were compared, and despite longer lengths of stay in home care programs, both the per diem costs of care and total costs per patient were significantly (one-fourth of hospital costs) lower for those patients who were treated in the home care program.

A review of twenty studies on the cost-effectiveness of home care programs was presented in the journal, **Public Health Reports**, in 1979. The majority of evidence from the studies shows clearly that in terms of total costs, home care is indeed less expensive than extended care hospitalization per case treated.[6] Those studies reviewed concerning the effect of home health services on hospital admissions suggested that home care has a potential for averting the hospitalization of some patients.[7] Studies concerning the ability of home care to encourage early hospital discharge demonstrate that this occurred. In these studies the reduced cost per case of those patients referred to home care programs demonstrated that a home care program will lead to earlier hospital discharge.

The effect of home care on total health expenditures is more complex than comparing the cost of home care with other forms of care. Nestman and Bay's review of the Edmonton Home Care Program referred to earlier examines this issue. They found that the long length of stay in the Home Care Program raised total patient costs in the program sufficiently to eliminate any short run savings with respect to active treatment hospitals. However, they point out if enough patients are transferred to home care programs to effect a reduction in the fixed costs of the hospital, then substantial savings will accrue to the health care system as a result of the utilization of a home care program. In other words, if some hospital beds are closed, and patients transferred to home care, then system wide savings will occur.

This study also concluded that home care offers significant cost savings in the long run because of its potential to reduce the demand for care in active treatment hospitals, and thereby decrease the demand to build new active treatment beds. Hence, substantial savings in hospital operating and capital construction costs can be made.[8]

Conclusions similar to those reached by Nestman and Bay are also made in other studies. For example, LaVor and Callendar commenting in the journal, **Medical Care**, concluded that the immediate effect of increasing home care would be an increase in total health care expenditures. They predict that it would take 3 to 5 years before the effect of the greater availability of home health services on the use of hospitals and nursing homes would be appreciable.[9] They note that:

> "Home health care will not permit us to empty our institutions; those already in that system will likely remain there. Nor will it render these places obsolete; a need for this care setting will continue to exist. We can attempt to prevent entry into institutions where possible and encourage hospitals and physicians to shorten hospital stays by prescribing home health services. Only after these efforts take effect will home care begin to offset the costs and use of institutional care."[10]

From the preceding information it can be seen that co-ordinated home care would be an "add on" expenditure in the early years of its implementation. However, it is also clear that home care can moderate the increase in health care expenditures particularly during a period of rising demand for health services. Given the aging population in Nova Scotia, it is expected that demand for hospital services will indeed be increasing in the foreseeable future. This issue is addressed in the next section.

Another point is that co-ordinated home care will encourage the improved use of existing institutional services by facilitating the more efficient use of hospital beds and lower cost alternatives.[11] In this regard, the 1972 Report of the Nova Scotia Council of Health felt that excess capacity existed in Nova Scotia's hospitals and that rationalization had to occur to achieve improved productivity. The Report estimated that about 30 per cent of the patients in hospital could be treated elsewhere in various components of a progressive health care system of which home care would be a major part.[12]

The Aging Population

Another factor pertinent to the discussion of home care is the aging population in Nova Scotia. As the proportion of senior citizens continues to grow in our population, more and more demands will be made on our health care system, particularly hospitals. The following quote refers to Canada as a whole, but the argument applies to Nova Scotia as well.

> "By 2001, there will be proportionately more elderly Canadians than there were in 1976. The proportion of the population over 65 will increase from about 9% in 1976 to 11% by 2001. This increase in the actual number and proportion of elderly persons in Canada is very significant in light of the fact that in 1975 the elderly 9% of Canadians accounted for 39% of all patient-days in general and applied hospitals. Assuming the same utilization patterns this percentage of total patient-days would grow to 49% by 2001."[13]

As shown in Table 1, the proportion of the population over age 65, and over age 75, were greater in Nova Scotia than Canada as a whole in 1981. Population projections show that not only has this been true in the past, but the trend will continue through the year 2001.

Another population statistic worth noting is given in Table 2 which shows the population over age 75 as a per cent of the population over age 65. This table shows that a higher proportion of Nova Scotians over age 65, are in the over 75 category than is the case for Canada as a whole. Further, this gap is projected to widen through the 1990's to the year 2001.

From the projections cited above it is clear that programs and services that meet the needs of the elderly will have to be extended, and developed if the expected increase in demand for these services is to be met in the years ahead. In particular, the case for a home care program in Nova Scotia is strengthened by this argument.

Home care programs have often been developed primarily for the elderly and the following characteristics of the patients served are common to home care programs in Canada: (1) 70% to 75% are over age 65; (2) 75% are long-term or chronically ill; (3) a large majority are females.[14] Clearly, the development of a home care program in Nova Scotia should be considered as a health care option to meet the needs of elderly Nova Scotians.

Table 1
Projected Population by Age 1981-2001

	% of Total Population 65+		% of Total Population 75+	
Year	**Canada**	**Nova Scotia**	**Canada**	**Nova Scotia**
1981	9.7	10.9	3.6	4.1
1986	10.0	11.2	3.9	4.4
1991	10.7	11.6	4.3	4.9
1996	11.0	11.5	4.6	5.2
2001	11.2	11.4	5.0	5.4

Source: Statistics Canada

Table 2
Projected Population By Age 1981-2001

	Population 75+ As a Per Cent of Population 65+	
Year	**Canada**	**Nova Scotia**
1981	37.4	37.6
1986	38.8	39.2
1991	40.1	45.5
1996	41.4	45.4
2001	44.4	47.1

Source: Statistics Canada

Developing Home Care: Additional Factors to be Considered

Evidence from other provinces, the concern for an increasingly aged population, and the potential cost-effectiveness of home care suggest that serious consideration should be given to the establishment of a formal co-ordinated home care program in Nova Scotia. The implementation of a co-ordinated home care program will require careful planning if such an undertaking is to be effectively integrated into the existing health care system. In taking such a step, several fundamental issues which will have a significant impact on the direction and organization of a home care program should be addressed. These issues are outlined below.

Goals

As pointed out in the discussion on home care in other provinces, the goals and scope of home care programs vary from province to province. Hence, the delivery systems that have been established vary as well. Careful consideration should be given to the purpose and goals of home care in Nova Scotia. Included in this consideration is the fundamental question of whether or not home care should primarily meet health needs, or attempt to meet both health needs and social support needs as well. A rigorous assessment of the spectrum of public needs is vital so that services can be tailored to legitimate needs.

Given the concerns that were brought before the Select Committee by various groups and individuals, the Committee favours a statement of goals for co-ordinated home care in Nova Scotia that is broad; one that will address both health and social needs. Such a broad approach will allow the delivery of prevention and health maintenance services, personal support services which allow persons to function independently at home, as well as active medical services. This approach will facilitate the integration of services like the Home Life Supports Program into a co-ordinated home care program and increase the number of options for care available to patients.

Efficient Use of Resources

A central question in the provision of home care services is who should deliver the service. Should the service be provided by a government agency or department, or should existing agencies in the voluntary sector be funded to provide the service? Currently, there is much debate and discussion around the role of the VON and the Department of Health's public health nurses in the provision of home nursing care in a proposed home care program.

As was pointed out earlier in this chapter, service providers may be government employees or may be employed by independent organizations who are funded by government to provide the services which fall within the parameters of the program. The question of whether government should directly provide the services or fund some other agency to provide the service should be addressed with careful consideration to economies of scale and the technical efficiency of manpower. Staff resources utilized in the provision of service must match the required needs for care. In addition to these considerations, the valuable contribution that can be made by the voluntary sector to a home care program must be recognized.

Where possible in the province, the Committee therefore favours the utilization of existing resources and the enhancement of community participation in the provision of home care services.

Administration and Co-Ordination

Whatever organization arrangement is chosen for the delivery of home care services, a central, co-ordinating function will have to be maintained. Fundamental to this function is an information system which will provide sufficient reliable data to decision makers. The information system should provide information which is useful in both strategic planning and in management control of the program. To ensure that the home care program has its desired results, there must be an evaluation process whereby information on the utilization of resources is collected and analysed in order to make necessary adjustments to the program.

Finally, a home care program must have adequate financial resources to function effectively. Currently, certain home care services, such as homemakers services, can be cost shared with the Federal Government under the Canada Assistance Plan. As was pointed out in the chapter on Health Care Financing, Nova Scotia presently commits a large portion of its resources to health. For Nova Scotia to develop a comprehensive, co-ordinated home care program attention must be turned to Federal Government contributions to health care. Mechanisms which would allow increased federal support need to be developed.

Recommendations

In view of the evidence reviewed, the Select Committee on Health recommends:

1. **That the Government of Nova Scotia fully implement a comprehensive, co-ordinated home care program for the residents of Nova Scotia.**

2. **That in the development and implementation of a comprehensive co-ordinated home care program, existing services and resources be utilized wherever possible and appropriate.**

3. **That the home care program be provided by a multi-disciplinary team which can deliver a broad range of services and have firm connections with the full spectrum of health and social services.**

4. **That the home care program be organized to facilitate co-ordination of the services and good communication between the referring agency, or individual, and the home care program.**

5. **That the home care program include a core of services including homemakers, nursing, occupational therapy, physiotherapy, and the active participation of physicians, within the multi-disciplinary team, to ensure regular case conferencing so that relevant information on the patient and emergency consultation is always available for home care patients.**

6. **That the Government of Nova Scotia establish an advisory committee that is representative of a cross-section of appropriate health and social service professionals to advise the government on the planning of a co-ordinated home care program.**

Footnotes - Chapter 6

1. Hammond, John, "Home Health Care Cost Effectiveness: An Overview of the Literature", in **Public Health Reports**, July - August 1979, Vol. 94, No. 4, page 306.

2. Shapiro, Evelyn, **Home Care: A Comprehensive Overview**, National Health and Welfare, Ottawa, 1979, page 3.

3. Information in this section was obtained from discussions with officials involved in the home care programs of the various provinces and the following publication.

Canada, **Profiles on Home Care/Home Support Programs**, Health and Welfare Canada, Ottawa, 1982. The information which is represented in this section on home care programs in the provinces is taken from this publication.

4. Canada, **Manitoba/Canada Home Care Study**, Health and Welfare Canada. Ottawa, 1982, page 26.

5. Nestman, Lawrence and Bay, Kyung, **An Evaluation of the Edmonton Home Care Program** (1973-1976). Medical Services Research Foundation of Alberta, The University of Alberta, Edmonton, 1977, page 236.

6. Ibid, page 327

7. Ibid, page 330

8. Ibid, page 340

9. Hammond, Op. Cit. page 311

10. Hammond, Op. Cit. page 311

11. Hammond, Op. Cit page 311

12. Nova Scotia, **Health Care in Nova Scotia. A New Direction for the Seventies**, The Report of the Nova Scotia Council of Health, Halifax 1972, pages 20-21.

13. Canada, **Health Field Indicators, Canada and the Provinces**, Department of National Health and Welfare, Health and Social Policy Directorate, Ottawa, 1979, page 9

14. Shapiro, Op. Cit. page 20

7 Medicare and Hospital Insurance

Introduction

Submissions made to the Select Committee on Health were very supportive of Canada's medicare and hospital insurance system. In total, seventy-two recommendations were made, in thirty-one submissions, pertaining to medicare and hospital insurance issues. These recommendations were concentrated in three main areas: thirty-two recommendations were aimed at extending the coverage of the current M.S.I. program to include additional supplies and/or services; twenty-one recommendations advocated that the Provincial Government ban user fees, and extra charges for health care services; an additional ten recommendations gave general support to Canada's Health Insurance System by requesting that the Provincial Government reaffirm its support for the five basic principles of Canada's Health Insurance System, namely portability, comprehensiveness, accessibility, public administration of health insurance, and universal coverage. The remaining nine recommendations dealt with a variety of issues including the geographic distribution of physicians in Nova Scotia.

To some extent events of the day overtook the Select Committee on Health with respect to Canada's and Nova Scotia's Health Insurance System. During the period when the Select Committee on Health was holding public hearings a national debate, essentially focusing on the financing of health care, began as a result of the Federal Government's decision to introduce the Canada Health Act. At the provincial level, Premier Buchanan stated that "as long as I am Premier we will not have user fees" in Nova Scotia's hospitals. Finally, while this Report was being written the Canada Health Act, which replaces the Hospital Insurance and Diagnostic Services Act, and the Medical Care Act became law on April 17, 1984.

The Canada Health Act provides that as of July 1, 1984 provinces that permit extra billing by doctors, or charge user fees for hospital services will lose one dollar of the cash portion of federal transfers to provinces for health care under Established Programs Financing, for every extra dollar patients pay. Nova Scotia does not have user fees but extra billing by doctors amounted to approximately $3.5 million in 1983.

Despite the passage of the Canada Health act, the fact that Nova Scotia does not have user fees, and the Premier's statement that the Government has no intention of introducing user fees, the Select Committee on Health felt that given the emphasis placed on the subject of direct charges for health care in submissions to the Committee, the subject should be addressed in this Report.

The next three sections of this chapter address the subject of direct charges for health care, beginning with definitions of user fees, premiums, and extra billing; this is followed by a review of the situation with respect to direct charges across Canada; the third section reviews the evidence regarding the impact of direct charges on health care. The fourth section briefly reviews elements of the Canada Health Act, and outlines possible implications for Nova Scotia.

The final section of the chapter addresses the question of some health care services and supplies that could be added on to the current health insurance system in Nova Scotia. This section is selective and does not attempt to list and priorize every single health service or supply that could conceivably be covered by the health insurance system "in a world of infinite resources". Neither does the section deal with services provided in a home care program that would have to be covered by the health insurance system. These issues are referred to in chapters on Home Care and Hospitals.

Direct Charges: Definitions

The term direct charges describes a variety of mechanisms used by some provinces to raise revenue for health care other than through taxation mechanisms. **Direct charges** can be defined as any out-of-pocket expense incurred by a patient at the point-of-service as a direct result of requiring and receiving health care services.

Direct charges in the form of **user fees** are commonly applied to patients for hospital services and other health care institution services. In hospitals, charges can be applied to either inpatient or outpatient services, or both, and in the case of inpatient services fees can take the form of per diem charges which are not covered by the provincial hospital insurance plan. Hospital admission charges are another form of institutional user fee.

Direct charges also occur when physicians directly charge patients a fee for service which is in addition to any fee payable to the physician by the provincial medicare insurance plan. This practice is commonly referred to as **extra billing**, **billing above tariff**, or **balanced billing** which is the term used by the Canadian Medical Association.

Premiums are another form of direct charges to patients. **Premiums** are charges levied on residents on a monthly, quarterly or annual basis, and their payment is required if the resident is to be eligible for service covered under the provincial hospital and medical insurance plans.

The final item requiring clarification with respect to defining direct charges is the subject of "opting out". **Opting out** is the practice whereby physicians choose not to use the provincially approved fee schedule, or insurance mechanism. Instead, they charge patients directly for services. Patients are then eligible to be reimbursed by the provincial insurance plan at the provincially approved rate and any amount in excess of that rate is borne by the patient.

Direct Charges: A Provincial Review[1]

The manner in which provinces fund their medical and hospital insurance programs varies considerably. All provinces provide funds from their general revenue sources or from a dedicated tax. However, Ontario, Alberta, British Columbia and the Yukon all have some form of premium requirement for medical and/or hospital services. In 1982 premiums for a family ranged from a high of $648 per annum in Ontario to $228 per annum in Alberta.[2]

Charges for hospital services are applied in seven provinces - Newfoundland, New Brunswick, Quebec, Ontario, Manitoba, Alberta and British Columbia. In Newfoundland, Alberta, Manitoba, Quebec and Ontario hospital charges are levied on patients for inpatient services only. New Brunswick and British Columbia charge for both inpatient and outpatient services.[3]

Extra billing, the practice of physicians charging patients directly a fee over and above the government sponsored insurance charge, exists in nine provinces. The one exception to this is British Columbia where legislation prohibits extra billing, although physicians can opt out.

In Nova Scotia there are no charges for hospital services and no premiums required of residents. Extra billing was practiced by 787 physicians in the twelve month period ending on March 31, 1983. During this period extra billing or billing above tariff amounted to 2.9% of total fee for service billing to the insurance plan or $3,474,652.[4]

The Impact of Direct Charges

There is a growing body of material relating to the effects of direct charges in their various forms on health care costs and on the utilization of health care services. One study, **User Charges for Health Services**, was commissioned by The Committee on Health Services of the Ontario Council of Health in 1978. This extensive study drew upon Canadian and international experience and reviewed existing professional and scholarly research reports dealing with the issue of direct charges for health care services. Some of the findings relevant to this discussion are presented below:

1. **Reduction in utilization**. Where user charges are involved in the payment of medical services, there is an immediate and in some instances a long-term reduction in the utilization of services by patients.[5]

   It should be noted that the reduction in utilization varies with the amount of user charge, the type of service requested by the patient, the severity of illness, and discretionary decisions made by patients. For instance, it has been demonstrated that relatively small user charges have a smaller effect on utilization than larger user charges. As well, modest charges affect the utilization of medical services more than the use of hospital services.[6]

2. **Selective Impact**. The introduction or the raising of user charges results in sharp and consistent differences in the utilization of medical and pharmaceutical services by the social circumstances of individuals. The groups who are most affected are the socially disadvantaged, the poor and the elderly.[7]

3. **Rebound Effect**. There is clear evidence in some programs involving user charges that a rebound effect developed involving the partial displacement of care from less to more expensive categories of services.[8]

4. **Patient Abuse of Services**. There is no evidence that user charges result in a substantial decline in the unnecessary use of hospital and medical services.[9]

5. **Containment of Supply vs Demand**. Once the principles of universal comprehensive national health insurance have been established in most countries, the introduction later of high direct charges is usually found to be socially and politically unacceptable.[10]

6. **Documentation**. There is a lack of carefully designed studies involving the consideration of the direct social and economic effects of user charges on the utilization of services and the health status of a population.[11]

Although evidence exists to support the findings mentioned above, most research has dealt with only selected aspects of the direct charge issue and in no instance is a full range of requisite information available.[12]

In summary, the burden of recommendations made to the Select Committee on Health was that user charges should not be introduced in Nova Scotia. The evidence respecting the impact of user charges reviewed by the Select Committee on Health suggests negative effects far outweigh any positive effects that would result from their introduction.

In the case of premiums, this regressive form of taxation could be used to augment revenues earmarked for health care. However, the Committee favoured the use of progressive taxation instruments if additional revenue from provincial sources is necessary to finance health care.

The Canada Health Act

The discussion concerning direct charges has been given additional attention since the introduction of the Canada Health Act (CHA) by the Federal Government. The Act, which received Royal Assent on April 17, 1984, sets out the program criteria and conditions of payment, for the cash portion of the Federal contributions made to the provinces for insured health services, and payments made to the provinces for extended health care services. The insured health services covered by this legislation are all necessary hospital services, physician services, and surgical-dental services performed in a hospital. Extended health care services include nursing home, intermediate care, adult residential care, home care, and ambulatory care.

The criteria that a provincial health program must meet to be eligible for the full cash portion of the contribution are the familiar conditions of public administration, comprehensiveness, universality, portability and accessibility. The accessibility condition spells out that any financial barriers to access will not be tolerated by the Federal Government. With regard to universality, the Act implies that a person's premium-payment status should not be a factor in determining their eligibility to receive health services.[13] In those provinces which require the payment of premiums, non-payment of those premiums cannot be grounds for the denial of insured health services.

The conditions of payment that provinces must meet to be eligible for the full cash portion of the Federal contribution also include provision of information to the Federal Government, visibility (i.e. Federal contributions to the program have to be given appropriate visibility), and finally, extra billing and user charges must not be permitted except as outlined in the Regulations attached to this Act.

Where a provincial plan fails to satisfy any one of the program criteria, or the province fails to comply with the conditions of payment, that is, provision of information and visibility, the Act provides that the cash portion of the Federal contribution or payment may be reduced. This reduction is **discretionary** and must be preceded by consultation with the province.

Where a province fails to comply with the condition of payment relating to extra billing and user charges, the Act provides for a **non-discretionary** reduction of the cash portion of the Federal contribution by the amount charged through extra billing or user charges.

All of the foregoing aspects of the Act were included in the first draft of the CHA which received first reading in Parliament on December 12, 1983. Between the time the Act was introduced and received Royal Assent a number of amendments were included in the legislation. One of these amendments provided for the broadening of the definition of who is able to deliver insured health services by indicating that services could be rendered by other health care practitioners if the law of the province so permits. For example, nurses could provide insured health services if the province desired.

Another important amendment resulted in the inclusion of a clause providing for "conciliation or binding arbitration by a panel that is equally representative of the provincial (medical or dental) organizations and the province, and that has an independent chairman"[14] as a means for the settlement of disputes, relating to the compensation of medical practitioners and dentists.

The provinces see the Canada Health Act as an incursion into provincial jurisdiction. The non-discretionary reduction in the cash portion of the Federal contribution to a province which fails to comply with the terms of the Act (i.e. a province which permits physicians to extra bill and hospitals to charge users) will be in the amount charged through extra billing or user charges in that province. As such it will be a dollar for dollar reduction in Federal contributions.

Clearly, if the provinces do not ban user fees the reductions in Federal contributions will vary from province to province and will be greatest in Alberta, British Columbia and Ontario. In the case of Nova Scotia the monies collected by physicians through extra billing will be subtracted from the Federal cash contribution to the Province's Health Services Insurance Program.

In 1983, a total of about $3,500,000 in billing above tariff charges was reported for physicians in Nova Scotia. Although this amount is small compared to other provinces, physicians and the Minister of Health have viewed extra billing as a "safety valve" allowing doctors to receive additional income if they are dissatisfied with the settlements agreed to with provincial governments. As well, many physicians view extra billing as one symbol of their professional independence and freedom to define the terms of their relationship with their patients.

The provision of arbitration and conciliation in the new Act appears to satisfy the medical community's desire for flexibility in the settlement of remuneration concerns. However, it is not viewed positively by the provinces who see it as having the potential to force the provinces into high settlements with the professional groups.

Essentially the CHA is concerned with the basic principles of medicare and many important issues concerning health care are not addressed in the Act. Discussion and negotiation will have to occur between the professional associations and the provincial government to ease the transition to an environment in which extra billing is not permitted.

Additions to the M.S.I. Plan

There were many recommendations made to the Select Committee on Health regarding the extension of coverage of the current M.S.I. plan to include additional

insured services and supplies. Volume I does not cover every recommendation proposing extension of M.S.I. services. Often recommendations were very general, consequently they could not be adequately assessed by the Committee. However, recommendation number four below, suggests some additions to the M.S.I. plan that the Committee felt should be recommended for inclusion as insured benefits under M.S.I. at this time.

It should also be noted that recommendation number four addresses specific additions to M.S.I. Changes to the Health Services and Insurance Act implied in recommendations pertaining to a co-ordinated home care program, and hospitals are of a broader nature. The list of items presented below is not in any order of priority. Finally, additional information would be required to specify the precise cost of these items and to identify the appropriate administrative mechanisms for their delivery.

Recommendations

The Select Committee on Health recommends:

1. **That user charges for health services not be introduced in Nova Scotia.**

2. **That progressive taxation instruments be used, instead of health care premiums, if additional provincial revenues are required to finance health care in Nova Scotia.**

3. **That the Minister of Health, after consultation with the Nova Scotia Medical Society, introduce legislation to comply with the Canada Health Act with regard to extra billing by physicians.**

4. **Subject to the availability of funding, the Health Insurance Commission be encouraged to provide improved free prescription drug service; additional rehabilitative services and supplies including: breast prosthesis; appliances for paraplegics and quadriplegics; ostomy supplies for ostomates; aids for the visually impaired; and interpreter services for hearing or speech impaired where necessary for consultations with physicians.**

(It should be noted that Government members of the Committee felt that the additional recommended services to be provided under the Health Services and Insurance Act should be based on an economic needs test at this time. Opposition members of the Committee were of the view that these services should be provided on a universal basis. The Committee could not reach a consensus on this philosophical question.)

Footnotes - Chapter 7

1. The review of the situation with respect to direct charges reflects circumstances in the provinces up to May 30, 1984.

2. Canada, **Medicare: The Public Good and Private Practice**, National Council of Welfare, Ottawa, 1982, page 40

3. Ibid, Appendix C

4. Nova Scotia information provided by **The Nova Scotia Health Services and Insurance Commission**

5. Badgley, Robin F. and Smith, David R., **User Charges for Health Services**. A Report of the Ontario Council of Health, Toronto, 1979, page 7

6. Ibid, page 7

7. Ibid, page 7

8. Ibid, page 7

9. Ibid, page 9

10. Ibid, page 8

11. Ibid, page 9

12. Ibid, page 9

13. Manga, Pran, "Preserving Medicare: The Canada Health Act", in **Perception**, published by the Canadian Council on Social Development, Vol. 7, No. 3, 1984, page 14

14. Canada, **The Canada Health Act**, April 17, 1984, Section 12, clause 2(a) and 2 (b).

Appendix I

Summary of Recommendations By Selected Topic

1. Prevention
2. Hospital: Administration; Construction; Services
3. Medicare and Hospital Insurance
4. Education of Health Professionals
5. Consumer and/or Staff Involvement in Health Policy
6. Home Care Program
7. Health Education; Human Sexuality Education and Services
8. Mental Health
9. Community Health Services; Expanded Entry Points
10. Prenatal, Perinatal and Postnatal Concerns
11. Environment
12. Specific Women's Health Concerns
13. Occupational Health and Safety
14. Abortion
15. Specific Concerns of the Elderly
16. Occupational Therapy, Physiotherapy and Rehabilitation
17. Drug and Pharmaceutical Concerns
18. Dental Care
19. Vision Care
20. Learning Disabilities
21. Palliative Care
22. Other (e.g., Nutrition, Municipal Health Boards, Disabled)

Note: A list of the abbreviations used after each recommendation is included at the end of Appendix I.

1. Prevention

1.1 Raise the priority of and expand health promotion and preventive medicine services in a community setting (PHANS, VON, St. J.A., NSFL, HC/NDP, Zonta, WHEN)

1.2 Expand the range of insured health services to include prevention and rehabilitation (NSHC)

1.3 Shift funds from treatment to prevention in medical schools and public health training (SSEPA)

1.4 Proclaim mandatory seat belt legislation (Plaut, NSPCWA, NSACSW, Loveridge, YRH)

1.5 Provide health promotion programs to encourage healthy lifestyles (OHNA, Wuerr, St. J.A., Casey, NSACSW)

1.6 Promote healthy living through the Nova Scotia Lifestyle Foundation (Harlow)

1.7 Develop risk reduction programs in Nova Scotia (HED/DAL)

1.8 Integrate allied health professionals with family physician care to encourage preventive care (FM/DAL)

1.9 Shift the emphasis in health care from treatment to prevention (FSENS, Wuerr, MHHfx)

1.10 Provide health education materials in prominent locations (Lambie)

1.11 Provide a daily non-competitive physical fitness program in schools (NSPCWA, Angels, MSNS)

1.12 Spend more money on prevention, especially in nutrition, family planning and physical fitness (NSPCWA, NSDA)

1.13 Promote physical, mental and spiritual fitness (CPCI)

1.14 Department of Health develop new initiatives in health education and prevention (FHP)

1.15 Provide citizens with smoke free environments in specific public places (NSCSH, Angels, MSNS)

1.16 Provide non-smoking N.S. Government employees the right not to be exposed to second hand smoke (NSCSH)

1.17 Increase the tax on cigarettes to discourage consumption (NSCSH)

1.18 Support voluntary organizations providing smoking cessation programs (NSCSH)

1.19 That the principle of prevention underlie the appointment to and operation of boards, commissions and committees (BONDING)

1.20 Conduct pap smears, breast exams, etc., through special clinics where not already available (WWHAA)

1.21 Use dedicated tax on alcohol for addiction programs (CBCODD, YARCODD, SCODD)

1.22 Impose stiffer fines and longer licence suspensions for impaired driving (Angels, MSNS)

1.23 Recognize the social and economic factors leading to ill health and eliminate poverty (WHEN)

1.24 Legislate mandatory blood testing for impairment (MSNS)

1.25 Establish mandatory driver safety courses for motorists involved in alcohol related accidents (MSNS)

1.26 Improve methods for the early detection of disease (Casey)

1.27 View day care as an integral part of an holistic approach to preventive health care (LCWG, Sisters)

1.28 Re-educate families to accept responsibility for health care maintenance (Riddell)

1.29 Support improvements for cardiac care and the National Heart Foundation's attempts to reduce deaths due to heart attacks (NHF)

2. Hospital: Administration; Construction; Services

2.1 Do not build Camp Hill Medical Centre (Plaut, C-Ruffman)

2.2 Camp Hill Medical Centre to remain as first priority (Camp Hill, Infirmary)

2.3 Be aware of conditions of Infirmary (Infirmary)

2.4 Be aware of facility requirements at Camp Hill (Camp Hill)

2.5 Provide 52 new beds for rehabilitation (Rehab)

2.6 Re-examine trend to centralized institutions (ACGC)

2.7 Infirmary to continue as present (Plaut)

2.8 Build maternity hospital next to Izaak Walton Killam Hospital (Plaut)

2.9 Hospitals to change to a health orientation rather than sickness orientation (NSPCWA)

2.10 Place high priority on deficiencies at Grace (Grace I)

2.11 Build a new hospital for Grace Maternity as soon as possible (Grace I, Grace II)

2.12 Continue to upgrade regional hospitals (NSAHO)

2.13 Increase co-operation/communication between institutions, especially hospitals and homes for special care (NSAHO)

2.14 No bed closures on an across-the-board basis (NSAHO)

2.15 Implement three specific steps to reduce hospital costs: reduce fees paid to physicians in outpatient departments, job sharing and product selection (NSAHO)

2.16 Establish and provide funding for pastoral care departments in hospitals (HDCC, THERAPEIA)

2.17 Establish interdenominational committees to develop pastoral care departments (HDCC)

2.18 Pastoral care services be provided through contracts with Institute of Pastoral Training (IPT)

2.19 Make joint appointments of pastoral care chaplains (IPT)

2.20 Establish Advisory Committee on pastoral care in each hospital (IPT)

2.21 Government should increase funding to IPT (IPT)

2.22 Recognize that the Grace delivers a high standard of care (Grace II)

2.23 Abbie Lane and Camp Hill Hospitals should not be amalgamated (C-Ruffman)

2.24 Consider implementing special grants for high-tech equipment in regional hospitals (YRH)

2.25 Expand radiology and nuclear medicine services at Sydney City Hospital (SCH)

2.26 Expand cardiovascular services, hemodynamic monitoring, and pacemaker services in Cape Breton (SCH)

2.27 Provide outpatient dietitian services in hospitals (NSDA/CB)

2.28 All hospitals in Cape Breton should have access to part-time dietitians (NSDA/CB)

2.29 Install bacteriological laboratory facilities in local hospitals (MCI)

2.30 Institute province-wide bargaining for hospital workers (NSNU)

2.31 Government funds not to be used to challenge decisions of government boards (NSNU)

2.32 Show more discretion in appointment of hospital boards (NSAHO)

2.33 Re-open contract with pathologists of Victoria General Hospital (PA)

2.34 Ensure better utilization of emergency room facilities and communication with community medical doctors and hospitals (FM/DAL)

2.35 Involve family physicians in hospital care in Metro (FM/DAL)

2.36 Improve communication between emergency and family medical doctors (FM/DAL)

2.37 Establish peer review committees for hospitals (CBPCI)

2.38 Replace St. Martha's with a new facility (St. Martha's/Bd., St. Martha's/MS, LS)

2.39 Develop ambulatory care program as an alternative to inpatient hospitalization (St. Martha's/Bd.)

2.40 Expand St. Rita Hospital to accommodate new services (St. Rita)

2.41 Redistribute beds in Cape Breton so that no beds in St. Rita Hospital are closed (St. Rita)

2.42 Establish extended care beds in Sydney area (St. Rita)

2.43 Provide funds to general hospitals to cope with alcoholics requiring medical attention or expand addiction centre services (St. Rita)

2.44 Revise the sterilization policy at St. Rita Hospital (FPRTS)

2.45 Continue recruitment of specialized medical staff at St. Martha's (St. Martha's/MS)

2.46 Upgrade and replace radiology equipment at St. Martha's Hospital (St. Martha's/MS, LS)

2.47 Renovate pediatric ward, nursery, Dept. of Obstetrics and Outpatient Dept. at St. Martha's (St. Martha's/MS, LS)

2.48 Continue to provide space for specialists at St. Martha's Hospital (St. Martha's/MS)

2.49 Establish priorities for Pastoral Care implementation as follows: (a) tertiary, (b) regional, (c) nursing homes, (d) community hospitals, (e) other health care facilities (THERAPEIA)

2.50 Government of N.S. continue to support the existence of denominational health care institutions (ADHCC)

2.51 Regionalization should not preclude voluntary denominational health care institutions (ADHCC)

2.52 Government to re-examine funding for voluntary denominational health care institutions (ADHCC)

2.53 Strengthen regulations re: safety and registration of x-ray equipment and facilities (NSSMRT)

2.54 Establish a quality assurance program re: x-ray equipment and practices (NSSMRT)

2.55 Designate a qualified individual to be responsible for x-ray safety within each hospital (NSSMRT)

2.56 Ensure that only qualified physicians be permitted to requisition medical imaging (NSSMRT)

2.57 Ensure that only certified Medical Radiation Technologists operate medical imaging devices (NSSMRT)

2.58 Physicians should be more discriminating regarding hospital admissions (Riddell)

2.59 Reduce the number of heroic life saving measures in intensive care units (Riddell)

2.60 Improve hospital services in the Sydney area (Sweet)

2.61 Reduce growth in management positions in hospitals (NSNU)

2.62 Lower the number of hospital days (Sc.N. DAL)

2.63 Close selected hospital beds (Sc.N.DAL)

2.64 Permit parents to room-in with children in hospital (NSACSW)

2.65 Dept. of Health to review health care management structure (NSNU)

2.66 Establish and staff an adult cystic fibrosis clinic (CF)

2.67 Provide nutritionists in health units and at Infirmary Hospital (Lambie)

3. Medicare and Hospital Insurance

3.1 Recognize and protect five basic principles of Canada's Health Insurance system (FSENS, CPCI, WDLC, RNANS, NSHC, NSFL, WHEN, NSHC/P)

3.2 Ban all forms of user fees (NSHC, Plaut, RNANS, FSENS, NACSW, CBPCI, PHANS, NSFL, WDLC, BCTWIU, CBRLA, WHEN, NSHC/P, NSHC/CB, NC/NDP)

3.3 Eliminate surcharges/user fees for rehabilitation services (Rehab)

3.4 **Nova Scotia Government to make a recommitment to prepaid hospital/medical insurance (NSHC, FSENS, NACSW)**

3.5 MSI to cover optometric referrals/extra benefits (NSAOP)

3.6 MSI to cover nursing home care (Truro, NC/NDP)

3.7 Include rehabilitation under insured services (NSHC, NC/NDP)

3.8 MSI to cover nurses and other health professionals performing medical care (RNANS, WHEN)

3.9 Charge neither the patient nor the physician for the use of public medical facilities or procedures (CBPCI)

3.10 Introduce universal coverage for ostomy supplies with financial limits ($300 per year) or shared costs (Ostomy)

3.11 Monitor the cost of stoma supplies provided by Pharmacare and consult enterostomal therapist when usage exceeds $300 per annum (Ostomy)

3.12 Cover costs of providing an interpreter for the deaf for health services (MACSBD)

3.13 MSI to cover the cost of hearing aids (CCDNS)

3.14 MSI to cover medical/surgical/rehabilitative supplies for paraplegics and quadriplegics (CPA, DCSC, LEO, CIDS, Rehab)

3.15 Correct imbalance in geographic distribution of health professionals and facilities (NSFL, MDC)

3.16 Press Federal Government for monies to insure extended health services (RNANS, NSFL, WHEN)

3.17 Insure all aspects of extended health services (SCH, RNANS, YRH)

3.18 Ban extra billing and raise additional health care dollars through income tax systems (HC/NDP)

3.19 Expand MSI to cover preventive procedures and psychological counselling (HC/NDP, NC/NDP)

3.20 MSI to cover costs of home care (HD/NDP, NC/NDP)

3.21 Provide incentives for physicians to locate in rural areas (Loveridge)

3.22 MSI to cover out-of-province hospitalization when the patient is referred by a physician (MDC)

3.23 Department of Health to assume responsibility for level 3 patients currently in homes for special care (MDC)

3.24 Introduce collective bargaining for physicians (NSHC, NACSW)

3.25 Monitor health system to ensure equality in Nova Scotia (PPANS)

3.26 Ensure that funding for programs is conditional on uniform delivery of services (PPANS)

3.27 N.S. Government to support recommendations re: banning user fees, expanding insured services, etc. in negotiations on the Canada Health Act (NSHC)

3.28 MSI to cover transportation costs for patients requiring medical care (NSHC, NSFL, NC/NDP)

3.29 N.S. Government to resist the introduction of the Canada Health Act (NSMS)

3.30 Government of Nova Scotia to promote resumption of federal/provincial consultation re: cost sharing (NSMS)

3.31 Prevent private corporations from controlling any part of our health care system (MacDonald)

3.32 Evaluate the effectiveness of federal/provincial hospital and medical programs (MSNS)

4. Education of Health Professionals

4.1 Re-establish funding for Family Medicine (FM/DAL, Med/DAL)

4.2 Fund clinical facilities for Family Medicine in hospital (FM/DAL)

4.3 Establish manpower targets for physicians in the Maritimes (Med/DAL)

4.4 Reduce N.S. share of resident stipends (Med/DAL)

4.5 Examine adequacy of formula financing for physicians (Med/DAL)

4.6 Dept. of Health continue to support continuing education of health professionals (Con-Ed-DAL)

4.7 Professional training to include needs of women (NACSW)

4.8 Improve training re: child abuse and establish an information and referral service (NSACSW)

4.9 Train physicians in hospital functioning and cost considerations (NSAHO)

4.10 Establish internship requirement for two year nurses (NSAHO)

4.11 Provide Dalhousie with appropriate funding for health care programs (Pres. DAL)

4.12 Improve arrangements for health care education planning (Pres. DAL)

4.13 Provide more training re: Learning Disabilities for health professionals (DALD, WALD, ACLD/YAR, PCLDA)

4.14 Expand and update stipend program for physiotherapy (Sc.Phy. DAL)

4.15 Appoint faculty member as consultant in physiotherapy education (Sc.Phy.DAL)

4.16 Train and employ additional epidemiologists and specialists (FHP)

4.17 Continue continuing education for physicians, especially in prevention (FHP)

4.18 Ensure continuity of occupational therapy program at Dalhousie (FHP)

4.19 Establish Health M[illegible]wer Planning Office (FHP)

4.20 No cuts to clinical education program in hospitals (FHP)

4.21 Establish co-ordination committee with Dalhousie re: Health Sciences Education (FHP)

4.22 Dept. of Health and Education to establish joint committee re: common concerns (FHP)

4.23 Provide education program for physicians re: prescription drugs (PANS)

4.24 Train health professionals in field of human sexuality/women's health (PPANS, NSPCWA, AFL)

4.25 Improve training for professionals re: benzodiazephine effects (NACSW)

4.26 Develop formalized training for homemakers (RCHC, NWHSS)

4.27 Provide professional development training for chaplains (IPT)

4.28 Place more emphasis on ostomy care in health education curriculums (Ostomy)

4.29 Provide more education for health professionals re: hearing impairment and deaf culture (MACSBD)

4.30 Ensure that medical training curriculums include community support for the disabled (CAMR)

4.31 Require medical students to do some training in regional hospitals (Loveridge)

4.32 Provide continuing education for personnel in Type III programs especially physiotherapists and occupational therapists (SCH)

4.33 Government to support training of health educators (HED/DAL)

4.34 Continue hospital based and diploma nursing education program (St. Martha's/Bd.)

4.35 Provide palliative care education for staff, volunteers and family (Sisters)

4.36 Require and provide periodic retraining for officials in the Department of Health (CAPE)

4.37 Government to rationalize licensing and registration systems for health personnel (MSNS)

4.38 Government to put on hold proposals for up-grading professional qualifications of allied health personnel pending rationalization (MSNS)

5. Consumers and/or Staff Involvement in Health Policy

5.1 Include citizen and health worker participation in the planning and development of health care program and facilities (MHHfx, NSFL, WHEN, NC/NDP, NSHC, BONDING, ICEA, ACGC)

5.2 Include consumers in appointments to hospital boards (PCANS)

5.3 Show greater recognition of voluntary sector in health policy (VON, PPANS, CPCI, WWHAA, WHEN)

5.4 Include nurses in planning re: health care delivery (RNANS)

5.5 Increase funding for voluntary health organizations in preventive health system (PPANS)

5.6 Appointments to boards, commissions and committees should reflect demographic makeup of the community (BONDING)

5.7 Appointees should be accountable to their constituencies (BONDING)

5.8 Health related boards, commissions and committees should be open to the public and democratically operated (BONDING, C-Ruffman)

5.9 Government to develop patients' Bill of Rights (PRANS, Truro)

5.10 Review current arrangements for patient complaints (PRANS)

5.11 Distribute patients' rights material on admission to hospital (PRANS)

5.12 Establish program re: patients' rights and recourse (PRANS)

5.13 Appoint an independent patient advocate for Homes for Special Care (Truro)

5.14 All jurisdictions to restore professional participation in decision making (MSNS)

5.15 Involve NSDA in the planning and implementation of future health care programs (NSDA)

5.16 Establish community health boards on a regional basis to plan health services (BONDING)

5.17 Use Maritime groups for health planning research (Prev.Med/DAL)

5.18 Establish a grievance committee to hear problems regarding the health care system (MacDonald)

6. Home Care

6.1 Recognize the need for a co-ordinated home care program and implement as soon as possible (FSENS, NSHC/P, FM/DAL, CWL, Nestman, PHANS)

6.2 Home care program should contain health and social services, an assessment unit and a communication mechanism to ensure co-ordination (Nestman, NWHSS, RCHC, Riddell)

6.3 Introduce a co-ordinated Home Care Program utilizing voluntary and existing services whenever possible (VON, St.J.A.)

6.4 Develop a co-ordinated home care program utilizing nurses in assessment of clients (RNANS)

6.5 Home care should include physiotherapy, occupational therapy, inhalation therapy, and foot care (MHHP, NSSOT)

6.6 Department of Health to support Martha Home Health Project annually (MHHP)

6.7 Encourage rehabilitative care for seniors at home (CBRLA)

6.8 Professionals and non-professionals to be educated in the concept of co-ordinated home care (CWL)

6.9 Establish a professional advisory committee to advise on the planning of a provincial home care program (Nestman, MHHP)

6.10 Implement an integrated long-term care program (Nestman)

6.11 Recognize homemaker services as part of a home care program (RCHC)

6.12 Expand homemaker services seven day, twenty-four hour coverage (RCHC)

6.13 Develop a Home Care Program under a health resource centre-based regional concept (SCH)

6.14 Review present subsidies to ensure provision of homemaker services to those in need (NWHSS)

6.15 Provide long range comprehensive attendant home care program for the disabled (DCSC)

6.16 Revise provincial subsidy scale for homemaker services (RCHC)

6.17 Provide continuity of care on discharge to home (Sc.N.DAL)

7. Health Education; Human Sexuality Education and Services

7.1 Develop sequential life sciences study programs in schools (HED/DAL, NSPCWA, NASCW, KCDSB, WHEN, NSACSW)

7.2 Train health professionals in field of human sexuality (PPANS, NSPCWA)

7.3 Community Health Nurses should be more involved in contraceptive services (PPANS)

7.4 Promote responsible sexual behaviour through the media (PPANS, FPRTS)

7.5 Support training, education, research in health education (HED/DAL)

7.6 Equal access to contraceptive/birth control information (NACSW)

7.7 Establish, especially for adolescents, education and clinic services throughout the province for family planning and human sexuality (LCWG, NACSW)

7.8 Provide education programs on human sexuality and family life at the community level and in schools (PPANS, WWHAA)

7.9 Provide education for responsible sexual behaviour and family planning (CBRLA)

7.10 Provide services for pregnant teenagers and unwed mothers (AFL)

7.11 Identify and evaluate health education in schools and the community (HED/DAL)

7.12 Give priority to a school based smoking prevention program (NSCSH, Angels)

7.13 Extend health education program to senior high levels (KCDSB, Angels)

7.14 Improve co-ordination of health education among government departments (KCDSB)

7.15 Subsidize driver education programs in high school (Angels)

7.16 Introduce a comprehensive, mandatory, health education system in the schools (WHEN)

7.17 Department of Education to develop clearing house function re: resources and information available to schools (KCDSB)

7.18 Communicate and make available results of KCDSB curriculum project on health (KCDSB)

7.19 Make health programs consistent with guidelines found in teaching guides re: health education (KCDSB)

7.20 Give greater emphasis to nutrition in school curricula (Angels)

7.21 Provide public education on cardiopulmonary resuscitation (Casey)

7.22 Instruct the public in first aid via television (Casey)

7.23 Increase funding to groups involved in sex education (FPRTS)

7.24 That B. Ed. programs be required to include sex education (FPRTS)

7.25 Include SERENA Association in future discussions re: family planning programs (SERENA)

7.26 That the Government of Nova Scotia study the SERENA Association (SERENA)

8. Mental Health

8.1 Establish a regional mental health review committee to review care provided in mental health facilities (CMHA/CB)

8.2 Review impact of bed cutbacks on psychiatric patients (FM/DAL)

8.3 Increase remuneration for salaried psychiatrists (FM/DAL)

8.4 Abandon age criteria for Cape Breton Hospital (ADC, Sweet)

8.5 Cape Breton Hospital to be accessible 24 hours (ADC, CMHA/CB)

8.6 Cape Breton Hospital to establish 15-bed chronic alcoholic unit (ADC)

8.7 Review normalization policy to ensure proper support services (ADC)

8.8 Establish 10-bed psycho-geriatric unit at Cape Breton Hospital (ADC)

8.9 Emphasize prevention, education, community psychiatry in training of psychiatrists (MHHfx)

8.10 Examine community based services before additional capital expenditures are made (MMHfx)

8.11 Develop comprehensive community mental health system (MHHfx)

8.12 Dept. of Social Services to place a mental health expert on rehabilitation assessment committee (MHHfx)

8.13 Develop a case management system, a citizen advocacy program, support groups for families, and additional out-reach services (MHHfx)

8.14 Establish residential treatment centres and group homes for children (ACGC)

8.15 Fund youth co-ordinator for Mental Health Planning Board (ACGC)

8.16 Establish counselling component re: psychotropic drugs for seniors and women (LCWG, CPCI)

8.17 Sequential school health education program to emphasize mental health (MHHfx)

8.18 Churches and family service agencies to provide marriage preparation courses (AFL, NSPCWA)

8.19 Improve services to families and provide appropriate funding (AFL)

8.20 Appoint a case manager to assist families in the co-ordination of services of the mentally retarded (CAMR)

8.21 Accompany amniocentesis with counselling regarding services for handicapped children (CAMR)

8.22 Reduce time delays in assessing mental retardation (CAMR)

8.23 Provide full range of services in regional hospitals for the mentally retarded (CAMR)

8.24 Include an educational/developmental component in assessments for mental retardation (CAMR)

8.25 Develop a more expedient means of obtaining second party consent (CAMR)

8.26 Expand use of mental health facilities to include emergency treatment (CMHA/CB)

8.27 Provide psychiatric care in general hospitals (St. Rita)

8.28 Improve mental health services, particularly those concerning women (WHEN)

8.29 Improve mental health services in the Sydney area particularly for young people (Sweet)

8.30 Research and implement employee assistance programs (AFL)

8.31 Study impact of unemployment on mental health of Nova Scotians (AFL)

8.32 Provide respite care in one of the three provincial group homes in the Sydney area (Hamm)

8.33 Expand existing respite services (Hamm)

8.34 Explore with municipalities cost-sharing options for respite care (Hamm)

8.35 Phase out institutional respite beds in favour of community based services (Hamm)

9. Community Health Services; Expanded Entry Points

9.1 Improve co-ordination of health services (MCCB)

9.2 Community health centres should become focal points in the delivery of health care (FSENS, CBPCI, C-Ruffman, WHEN, NSHC/P, NC/NDP)

9.3 Restructure health system to emphasize community-based services (NSFL)

9.4 Emphasize alternatives to institutional care such as community clinics and nurse practitioners (Truro)

9.5 Provide a broader range of entry points utilizing nurses and other health professionals (VON, RNANS, NSNU, HC/NDP, WDLC, WHEN, NSHC/P, NC/NDP)

10. Prenatal, Perinatal and Postnatal Concerns

10.1 Dept. of Health to establish prenatal classes for single teens everywhere (PPANS, NSACSW)

10.2 Encourage and license midwives (PCANS, FORM, WHEN)

10.3 **Family centered maternity care be adopted/promoted in Nova Scotia (PCANS, NSPCWA, NSACSW)**

10.4 Encourage alternative birth settings in Nova Scotia (PCANS)

10.5 MSI to cover prenatal classes and programs (PCANS)

10.6 Encourage Federal Government to support prenatal family allowance as long as nutritional guidance is provided (PCANS, Lambie)

10.7 Provide funds for nutritional education materials and counselling during pregnancy (Lambie, Sisters)

10.8 Establish high risk registers for pregnant women (NSACSW)

10.9 End the distribution of baby formula packs (LCWG)

10.10 Develop a comprehensive regionalized plan for maternity care emphasizing family centered programs (PCANS)

10.11 Prenatal care and childbirth to be part of health education in school and community (PCANS)

10.12 Expand nutrition education programs in situations where young women would be exposed to them (Lambie)

10.13 Public Health Nurses to continue to follow-up "at risk" babies (CAMR)

10.14 HESS Committee to develop infant education program in Nova Scotia (CAMR)

10.15 Provide the best maternal child health care system to high- and low-risk families (ICEA)

10.16 End the application of silver nitrate to the eyes of the newborn (APSAC)

10.17 Expand provincial Reproductive Care Program to include home birth (APSAC)

10.18 Provide careful monitoring of and information regarding steps of prenatal development (PCLDA)

10.19 Fund additional fetal research (CBRLA, Sisters)

10.20 Establish a task force to study midwifery in Nova Scotia (APSAC)

10.21 Expand paramedical support programs to include all health professionals (PCANS)

11. Environment

11.1 Establish program to independently test new chemicals (SSEPA)

11.2 Introduce licensing procedure for new products (SSEPA)

11.3 Encourage greater use of non-chemical alternatives (SSEPA)

11.4 Require clear labeling of chemicals in consumer products (SSEPA)

11.5 Initiator to be responsible for chemically caused health problems (SSEPA)

11.6 Avoid nuclear technology (EAC)

11.7 Stress conversion to renewable energy sources (EAC)

11.8 Establish air quality monitoring in provincial government buildings (EAC)

11.9 Provide education re: wood burning equipment (EAC)

11.10 Ban uranium development and regulate mineral development (EAC, Plaut)

11.11 Government to take an active role in toxic waste management (EAC)

11.12 Assist farmers to convert to organic alternatives (EAC)

11.13 Ban herbicides (Plaut)

11.14 Identify, monitor and control potential health hazards (NSACSW, OHNA, CPCI)

11.15 Department of Health to have emergency plan for nuclear accident (NSACSW)

11.16 Inform people in advance of herbicide application (NSACSW)

11.17 Improved record keeping re: environment/incidence disease (LCWG)

11.18 Make greater use of epidemiological studies and surveys (SSEPA, CAPE)

11.19 Place scrubbers in new coal-fired generating stations (EAC)

11.20 Appoint personnel familiar with non-chemical farming practices to the Department of Agriculture (EAC)

11.21 N.S. work out problems of long-range storage for non-recyclable wastes with the public (EAC)

11.22 Insist on stricter legislation regarding the use of sprays, pesticides, and food additives (Wuerr)

11.23 Recognize the role of the environment as a determinant of community health (WHEN, NC/NDP)

11.24 Recognize the interdependence of environmental and health issues (CAPE)

11.25 Establish a pool of practising physicians to advise the N.S. Government on environmental health issues (CAPE)

11.26 Set up a planning body to assess health and social impacts of large development projects (Cappon)

11.27 Conduct more research to identify industrial pathogenic agents in the environment (NC/NDP)

12. Specific Women's Health Concerns

12.1 Middle aged women to be focus re: planning/research (NSPCWA)

12.2 Support well women's clinics and women's health groups (NSPCWA, NSACSW, LCWG, WHEN)

12.3 Professional training to include needs of women and foster positive attitude towards women (NSACSW, WHEN)

12.4 Study issues of violence/battering (NSACSW)

12.5 Make link between work histories and obstetrical problems (NSACSW)

12.6 Establish abuse identification procedures for hospital/medical doctors re: wife abuse (LCWG)

12.7 Provide financial support to agencies dealing with sole support mothers (AFL)

12.8 Assess discrimination against female physicians in practice and training (HC/NDP)

12.9 Establish a proper ratio of female therapists in mental health services at Yarmouth Regional Hospital (MDC)

12.10 Train nurses to provide services at well women clinics (LCWG)

12.11 Provide supports for battered women and their children (Sisters)

12.12 Create jobs for and protect jobs of working mothers (Sisters)

12.13 Government to adopt affirmative action program re: promotion of women in health care system (Zonta)

12.14 That an affirmative action program redress any biases preventing women from holding administrative positions (Zonta)

12.15 Provide incentives to encourage women to be promoted to administrative positions (Zonta)

12.16 Government of Nova Scotia to support women and their families to assist them to achieve a decent standard of living (WHEN)

12.17 Establish programs to reduce and eliminate child abuse and wife battering (MSNS)

12.18 Study results of Well Women's Clinic demonstration projects in southwest Nova Scotia for possible implementation (WWHAA)

12.19 Study issues of domestic violence and battering (NSACSW)

12.20 Provide financial support to agencies dealing with domestic violence (AFL)

13. Occupational Health and Safety

13.1 Strengthen legislation to give workers the right to refuse unsafe work (Plaut)

13.2 Establish roles for health/safety personnel (OHNA)

13.3 Establish orientation programs for workers re: occupational hazards (OHNA)

13.4 Establish a link between work histories and obstetrical problems (NSACSW)

13.5 Develop health and safety standards re: VDT's (NSACSW)

13.6 Develop employee assistance programs specific to employee needs (OHNA)

13.7 Protect confidentiality of health information of workers (OHNA)

13.8 Establish commission re: occupational health/safety (AFOEH)

13.9 Provide funds to expand occupational health nursing consultation services and increase research (OHNA)

13.10 Collect data on a continuous basis related to the health of workers (NSACSW)

13.11 Increase safeguards and preventive measures regarding hazardous substances and conditions in the workplace (HC/NDP)

13.12 Amend Worker's Compensation Act re: disability entitlement (NSAOP, MacDonald)

13.13 Occupational Health Nurses to conduct preplacement and periodic assessment of workers (OHNA)

13.14 Recognize the role of the workplace as a determinant of health status (WHEN, NC/NDP)

13.15 Institute a comprehensive public education program re: industrial hazards (CAPE)

14. Abortion

14.1 Adopt policy re: rights of unborn children (CBRLA, Sisters, CFL, ARL)

14.2 MSI not to pay for abortions unless valid medical reasons exist (CBRLA, CWL, Sisters)

14.3 Minister of Health to monitor therapeutic abortion committees (CBRLA, Sisters)

14.4 Provide information re: consequences of abortion (CBRLA, Sisters)

14.5 Use current abortion monies for other social services for women (CBRLA, Sisters)

14.6 Infants surviving abortion to receive life support (CBRLA)

14.7 Encourage adoption as an alternative to abortion (CBRLA, Sisters)

14.8 Province to approve abortion clinics (NACSW)

14.9 Minister be aware that he can reduce the number of abortions (CPHL)

14.10 That amniocentesis not be employed as a method to determine a defect in the fetus, with the purpose of aborting (CBRLA, Sisters)

14.11 Appoint an enquiry to investigate abortions in Nova Scotia (SOP)

14.12 Department of Education revise its curriculum to include abortion information at the Grade 8 level (FPRTS)

14.13 Nova Scotia Government monitor operation of Section 251 (4 c, d and 5, a, b) of the Criminal Code to ensure strict adherence (CBRLA, CWL, CFL, ARL, Sisters)

14.14 Department of Health seek alternatives to abortion (Sisters, CPHL)

14.15 Keep comprehensive records of abortion complications (CPHL)

14.16 Settle abortion issues in a responsible manner not on emotional or religious grounds (MacDonald)

15. Specific Concerns of the Elderly

15.1 Establish regional day care programs to provide medical and rehabilitative services to the elderly (SCH)

15.2 Staff the Department of Health to meet nutrition education needs of the elderly (NSDA/CB)

15.3 Prohibit private corporations from gaining control over nursing homes (MacDonald)

15.4 General hospitals should provide an out-reach program for the elderly (St. Rita)

15.5 Develop primary and secondary care programs focusing on the needs of the aged (St. Martha's Bd., NC/NDP, CPCI)

15.6 Investigation of deaths in Homes for Special Care to be mandatory (Truro)

15.7 All Homes for Special Care to be non-profit (Truro, NC/NDP)

15.8 Ensure more stringent licensing/monitoring/training for Homes for Special Care by the Department of Social Services (Truro, CPCI)

15.9 Ensure that there is less stress for seniors caused by government decisions (CPCI)

15.10 Replace present support methods with the Guaranteed Annual Income (CPCI)

15.11 Support pension reform (Truro)

15.12 Improve services for the elderly and provide retirement planning (NSPCWA)

15.13 Develop in-hospital and community based geriatric services in an appropriate balance (FM/DAL)

15.14 Study Homes for Special Care to examine present conditions (CPCI, Truro)

15.15 Study the Federal Report on Aging (Truro)

15.16 Homes for Special Care to follow nutrition staffing guidelines (NSDA/CB)

15.17 Define reasonable care as it applies to Homes for Special Care (Truro)

16. Occupational Therapy, Physiotherapy, and Rehabilitation

16.1 General practitioners to have open access to physiotherapy services (CPA)

16.2 Simplify methods of referral to physiotherapy (CPA)

16.3 Establish extended care facilities with rehabilitative emphasis (C-Ruffman)

16.4 Develop formally structured regional health programs with rehabilitative services (SCH)

16.5 Develop occupational therapy services for children with special needs in school and at home (NSSOT)

16.6 Provide staff for occupational therapy departments in regional hospitals (NSSOT)

16.7 Permit occupational therapists to make home visits (NSSOT)

16.8 Employ two additional enterostomal therapists at the V.G. Hospital (Ostomy)

16.9 Permit the two enterostomal therapists to be consultants to counties as required (Ostomy)

16.10 Encourage hospitals and health care agencies to utilize United Ostomy Association's services (Ostomy)

16.11 Expand funds for research in physiotherapy (Sc.Physio)

16.12 Develop a regional and community based network of occupational therapy services (NSSOT)

16.13 Department of Health appoint an occupational therapist to plan a community based occupational therapist program (NSSOT)

16.14 Form a voluntary stoma advisory committee to plan and evaluate ostomy care (Ostomy)

16.15 Private insurance to pay full cost of rehabilitation (Rehab)

16.16 Improve career structure for physiotherapists (Sc.Phy.DAL, CPA)

17. Drug and Pharmaceutical Concerns

17.1 Reform drug industry through government regulation and monitoring (WDLC)

17.2 Substitute generic drugs for brand name drugs whenever possible (BCTWUI, MacDonald)

17.3 Introduce permissive product selection legislation (PANS)

17.4 Refer questions of selection of product to Drugs/Therapeutic Committee (PANS)

17.5 Consider implementing a bulk purchasing system for drugs (PANS)

17.6 Require mandatory use of patient record systems in pharmacies (PANS)

17.7 Pharmacies establish a fee schedule based on charges to self-pay patients (PANS)

17.8 Limit payment for most drugs to 34 days supply excepting drugs for chronic illness (PANS)

17.9 Use computer technology for claims processing in drug benefit programs (PANS)

17.10 Limit the number of refills permitted by verbal transmission (PANS)

17.11 Drug Program Benefits to be limited (see recommendation 9) (PANS)

17.12 Monitor drug prescribing practices of physicians (PANS)

17.13 Data on tranquilizing drugs to be made public (NACSW)

17.14 Ensure universal access to drugs by government with annual deductible charged to residents (PANS)

17.15 That older persons who become drug addicts be allowed to stay on those drugs (MacDonald)

17.16 Maintain a record book of drugs for seniors (MacDonald)

17.17 Provide information with drug prescriptions re: generic/brand names, purpose, side-effects and frequency of dosage (MacDonald)

17.18 Provide treatment for withdrawal for prescription drugs such as valium (MacDonald)

17.19 Conduct more research re: the Provincial Government's drug benefit program (PANS)

18. Dental Care

18.1 Develop dental programs in schools run by para-professionals (WDLC)

18.2 Improve dental incentives program to ensure service to rural areas (MCI)

18.3 Hire more full-time dental hygienists (Angels)

18.4 Include dental health care in planning for comprehensive health care schemes (Dental)

18.5 Establish a Dental Manpower Advisory Committee to monitor the total manpower issue in Nova Scotia (Dental)

18.6 Provincial Dental Board to regulate all providers of dental care (Dental)

18.7 Expand provincial dental programs to include: children's program to 21 years of age; coverage of more services provided by dentists (Dental)

18.8 Government to adopt a common description for the services in the MSI benefit structure (Dental)

18.9 More Public Health Dentists to underserviced areas (Dental)

18.10 Permit Bursary Program dental hygienists to work within the private sector in underserviced areas (Dental)

18.11 Establish dental facilities in local hospitals (Dental)

18.12 Fund emergency care sites in hospital outpatient departments for weekend and holiday service (Dental)

18.13 Establish minimum levels of dental care in Homes for Special Care (Dental)

18.14 Government of Nova Scotia to provide funds for the installation of fluoridation equipment in all communities (Dental)

18.15 Improve dental care in the Sydney area (Sweet)

19. Vision Care

19.1 Provide diagnostic services for visual and audio perception in S.W. Nova Scotia (ACLD/YAR)

19.2 Government to work with all vision care specialists when developing policy (NSAOP)

19.3 Amend Hospitals Act to include optometrists in eye departments (NSAOP, Winslade)

19.4 DND to use optometrists (NSAOP)

19.5 CNIB to use optometrists in rehabilitation (NSAOP)

19.6 Medical doctors to refer directly to optometrists (NSAOP)

19.7 Government to establish regional vision training and glaucoma centers (Smit)

19.8 Government to attract more optometrists to Nova Scotia and utilize their skills (Smit)

19.9 Improve working arrangement between optometrists and ophthalmologists (Smit)

19.10 Government of Nova Scotia to expand existing PEP program utilizing existing services and resources (PEP)

19.11 Government of Nova Scotia to appoint an optometrist consultant to co-ordinate children's vision program (PEP, Winslade)

20. Learning Disabilities

20.1 Establish Learning Disabled (L.D.) Committee including relevant professions and parents to plan programs for the learning disabled (ACLD)

20.2 L.D. Committee to "bring together" a library of L.D. information (ACLD)

20.3 L.D. Committee to "bring together" an L.D. education program (ACLD, PCLDA)

20.4 L.D. Committee to develop a strategy to promote co-operation among L.D. related services (ACLD)

20.5 Develop early evaluation, and improve monitoring procedures for persons with minimal brain dysfunction (MBD) (ACLD/YAR)

20.6 Stress team work and co-operation with families re L.D. (Dept. of Education) (ACLD/YAR)

20.7 Provide support services for parents who must cope with learning disabled children in their home (WALD)

20.8 Increase public awareness of MBD and its symptoms and ramifications (PCLDA)

20.9 Maintain the co-ordination of learning disabilities (PCLDA)

20.10 Review for implementation the recommendations made at Department of Health's L.D. seminar in 1980 (PCLDA)

20.11 Improve and increase services re: L.D. (DALD)

20.12 Provide backup diagnostic services for L.D. (DALD)

20.13 Conduct further research re: brain function development (DALD)

20.14 Increase research on minimal brain dysfunction (ACLD/YAR, PCLDA)

21. Palliative Care

21.1 Set up program to meet needs of dying (CWL, CPCI)

21.2 Establish hospice support services in the home (C-Ruffman)

21.3 Develop and fund a co-ordinated comprehensive system of care for the terminally ill (Sisters, CWL, CPCI)

21.4 Develop easier access for patients who require institutional care (Sisters)

21.5 Government of Nova Scotia not to support euthanasia (Sisters)

21.6 Tailor palliative care to the needs of the patient and the family (Sisters)

22. Other (e.g. Nutrition, Municipal Health Boards, Disabled)

22.1 Provide additional funds to agencies dealing with the needs of the unemployed (AFL)

22.2 Improve ambulance services to rural areas (Loveridge, NC/NDP)

22.3 Use bilingualism as a criterion for the employment of health workers in Acadian areas (CCFANS)

22.4 Guarantee that public health and mental health personnel have bilingual training (MDC)

22.5 Maintain Health and Social Service programs (NWHSS)

22.6 Reimburse counties for demolition and property clean-up expenses (MCCB)

22.7 Amend regulations re: perc testing before subdivision approval (MCCB)

22.8 Improve legislation re: sewage disposal with respect to on-site sewage and grey water disposal (MCCB, RCBH)

22.9 Improve public education re: home building regulations (MCCB)

22.10 Include lot health assessments with deeds (MCCB)

22.11 No changes until Canada Health Act passed, Select Committee and Dental Review Committee report (NACSW, NSHC)

22.12 Discourage sign-out services in group physician practices (FM/DAL)

22.13 Make public health inspectors responsible for informing people denied a public health permit that Section 38(a) of the Act exists (RCBH)

22.14 Develop model documents for an appeal under Section 38(a) of the Health Act (RCBH)

22.15 Provide funding for low rental housing (Sisters)

22.16 Amend Human Rights Act to provide greater protection for the disabled (DCSC)

22.17 The Department of Social Services to increase earned income allowance by $100 per month for the disabled (DCSC)

22.18 Improve co-operation between the Department of Health and Social Services (ACGC, NSAHO, St. Rita)

22.19 Correct abuses in the health tax system and health related commissions (MacDonald)

22.20 Ensure better co-ordination of inter-disciplinary team approach (Sc.N.DAL)

22.21 Expand powers of municipal boards of health (MCCB, MCI)

22.22 Improve co-operation between provincial departments and local boards of health (MCI)

22.23 Study cost effectiveness of health delivery system (CBPCI)

22.24 Create a Maritime Health Research Council (MED/DAL)

22.25 Keep pace re: technological advances in delivery of health care (NSAHO)

22.26 Set up research fund and establish health service research unit (FHP/DAL)

22.27 Support research in selected areas of health (HED/DAL)

22.28 Return third community nutritionist position to Cape Breton (NSDA/CB)

22.29 Professional dietitians to be recognized as source of reliable nutrition information for the public (NSDA)

22.30 Fill three currently vacant public health nutritionist positions in Department of Health (NSDA)

22.31 Improve accessibility to quality nutrition care provided by professional nutritionists (NSDA)

22.32 Employ nutrition counsellors to work with low income families (NSDA/CB)

List of Abbreviations of Presenting Organizations and Individuals used in the Summary of Recommendations

ACLD	Atlantic Conference on Learning Disabilities
ACLD/YAR	Atlantic Conference on Learning Disabilities Yarmouth Branch
ACGC	Atlantic Child Guidance Centre
ADC	Antigonish Diocesan Charities
ADHCC	Antigonish Diocesan Health Care Council
AFL	Association for Family Life
AFOEH	Atlantic Foundation for Occupational and Environmental Health
Angels	The Students of Holy Angels High School
APNS	Association of Psychologists of Nova Scotia
APSAC	The Association of Parents and Professionals for Safe Alternatives in Childbirth of Nova Scotia
ARL	Antigonish Right to Life
BCTWIU	Bakery, Confectionery and Tobacco Workers International Union, Local 446
BONDING	Better Obstetrical and Neonatal Decisions in the New Grace
C-RUFFMAN	Dr. Linda Christiansen-Ruffman
Camp Hill	Camp Hill Hospital
CAMR	Canadian Association for the Mentally Retarded
CSAA	Canadian Sociology and Anthropology Association
CAPE	Citizen Action to Protect the Environment
Cappon	Dr. Paul Cappon
Casey	Dr. M.T. Casey
CBCODD	The Cape Breton Regional Advisory Board of the Nova Scotia Commission on Drug Dependency
CBPCI	Cape Breton Pensioners Concerned, Inc.
CBRLA	Cape Breton Right to Life Association
CCDNS	Co-ordinating Council on Deafness of Nova Scotia
CCFANS	The Comité Consultatif de Secteur de la Femme de la Fédération Acadienne de la Nouvelle-Ecosse
CF	The Metropolitan Halifax Chapter of the Canadian Cystic Fibrosis Foundation
CFL	Council for Life of Nova Scotia
CIDS	Community Involvement of the Disabled, Society
CMHA/CB	The Canadian Mental Health Association, Cape Breton Branch
Con-Ed-DAL	Division of Continuing Medical Education, Dalhousie University
CPA	Canadian Paraplegic Association, Nova Scotia Division
CPCI	Canadian Pensioners Concerned, Incorporated, Nova Scotia Division
CPHL	Coalition for the Protection of Human Life
CWL	Catholic Women's League
DALD	Dartmouth Association for Learning Disabilities
DCSC	The Disabled Consumers Society of Colchester

Dental	The Nova Scotia Dental Association
EAC	Ecology Action Centre
FHP/DAL	The Faculty of Health Professions, Dalhousie University
FM/DAL	The Department of Family Medicine, Dalhousie University
FORM	Families and Friends Organized for the Re-establishment of Midwifery
FPRTS	Family Planning Resource Team of Sydney
FSENS	Family Services of Eastern Nova Scotia
Grace I	Grace Maternity Hospital, 1st presentation
Grace II	Grace Maternity Hospital, 2nd presentation
Hamm	Mrs. Annie Hamm, Mrs. Carol MacIntyre and Mrs. Moira Steele
Harlow	Dr. C.W. Harlow
HC/NDP	Halifax Citadel New Democratic Party Association
HDCC	Halifax-Dartmouth Council of Churches
HED/DAL	The School of Recreation and Physical and Health Education, Dalhousie University
ICEA	International Childbirth Education Association, Incorporated
Infirmary	Halifax Infirmary
IPT	Institute of Pastoral Teaching
KCDSB	Kings County District School Board
Lambie	Professor Elizabeth Lambie
LCWG	Lunenburg County Women's Group
LEO	The Nova Scotia League for Equal Opportunities
Loveridge	Dr. Peter Loveridge
LS	Mrs. Lucile Sanderson
MacDonald	Mr. George K. MacDonald
MACSBD	The Metropolitan Area Community Service Board for the Deaf
Marshall	Mr. Michael Marshall
MCCB	The Board of Health of the Municipality of the County of Cape Breton
MCI	The Municipality of the County of Inverness
MDC	The Municipality of the District of Clare
MED/DAL	Faculty of Medicine, Dalhousie University
MHHfx	Mental Health, Halifax
MHHP	Martha Home Health Project
MSNS	Medical Society of Nova Scotia
NACSW	The National Action Committee on the Status of Women Health Committee
NC/NDP	The Colchester North New Democratic Party Association
Nestman	Professor L.J. Nestman
NSAHO	Nova Scotia Association of Health Organizations
NSAOP	Nova Scotia Association of Optometrists
NSACSW	The Nova Scotia Advisory Committee on the Status of Women
NSCSH	The Nova Scotia Council on Smoking and Health
NSDA	Nova Scotia Dietetic Association

NSDA/CB	Nova Scotia Dietetic Association, Cape Breton Branch
NSFL	Nova Scotia Federation of Labour
NSHC	Health Coalition of Nova Scotia
NSHC/CB	Health Coalition of Cape Breton
NSHC/P	Health Coalition of Nova Scotia, Pictou County Chapter
NSHF	Nova Scotia Heart Foundation
NSNU	Nova Scotia Nurses' Union
NSPCWA	Nova Scotia Progressive Conservative Women's Association
NSSMRT	Nova Scotia Society of Medical Radiation Technologists
NSSOT	Nova Scotia Society of Occupational Therapists
NWHSS	New Waterford Homemaker Services Society
OHNA	Occupational Health Nurses Association
Ostomy	The Nova Scotia Chapters of the United Ostomy Association, the Enterostomal Therapists of Nova Scotia
PA	The Pathologists Associates Group
PANS	The Pharmacy Association of Nova Scotia
PCANS	Prepared Childbirth Association of Nova Scotia
PCLDA	The Pictou County Learning Disabilities Association
PEP	Prevent Eye Problems Programme
PHANS	Public Health Association of Nova Scotia
Physio	The Nova Scotia Branch of the Canadian Physiotherapy Association
Plaut	Mr. Walter Plaut
PPANS	Planned Parenthood Association of Nova Scotia
PRANS	Patients' Rights Association of Nova Scotia
Pres./DAL	The President, Dalhousie University
Prev./Med/DAL	The Department of Preventive Medicine, Dalhousie University
RCBH	The Richmond County Board of Health
RCHC	Red Cross Homemakers' Committee
Rehab	Nova Scotia Rehabilitation Centre
Riddell	Mrs. Janet Riddell, R.N.
RNANS	Registered Nurses Association of Nova Scotia
SCH	Sydney City Hospital
Sc.N.DAL	The School of Nursing, Dalhousie University
SCODD	Shelburne Local Committee on Drug Dependency
Sc.Phy.DAL	School of Physiotherapy, Dalhousie University
SERENA	SERENA Association of Nova Scotia
Sisters	The Congregation of the Sisters of St. Martha
Smit	Dr. Henry Smit
SOP	The Senate of Priests
SSEPA	South Shore Environmental Protection Association
St.J.A.	St. John Ambulance
St. Martha's/Bd.	St. Martha's Hospital, Board of Directors
St. Martha's/MS	St. Martha's Hospital, Medical Staff
St. Rita	The Board of Directors of St. Rita Hospital
Sweet	Ms. Janet Sweet
THERAPEIA	THERAPEIA
Truro	Concerned Citizens from Truro/Homes for Special Care

VON	The Victorian Order of Nurses
WALD	The Wolfville Association on Learning Disabilities
WDLC	Windsor and District Labour Council
WHEN	Women's Health Education Network
Winslade	Timothy C. Winslade, O.D., F.A.A.O.
Wuerr	Mrs. Elizabeth Wuerr, R.N.
WWHAA	Well Women and Health Awareness Association
YRH	Yarmouth Regional Hospital
Zonta	The Zonta Club of Truro

Note: One hundred and thirty-one (131) groups and/or individuals submitted briefs to the Legislative Select Committee on Health.

Appendix II

Resolution No. 192

Hon. Roland Thornhill: Mr. Speaker, I hereby give notice that on a future day I shall move the following resolution:

Be it resolved that:

(a) This House declare, pursuant to the Rules and Forms of Procedure of the House of Assembly, that a select committee be established to inquire into the adequacy and delivery of health care in the province and all matters pertaining to health care facilities, and to consider and to report to this House the observations, opinions and recommendations of the members of the select committee respecting any matter relating to the adequacy and the delivery of health care in the province and health care facilities; and

(b) That this House declare, pursuant to Section 37A of the House of Assembly Act, that the select committee not be dissolved by prorogation of the House and that the select committee be authorized to continue its inquiry after the House prorogued; and

(c) Notwithstanding the said Rules or any Rules of the House, the Select Committee of the House be empowered to examine and inquire into all such matters and things as may be referred to the committee by this House, and from time to time report to the House the observations and opinions of the committee respecting matters and things referred to the committee, and the committee be further empowered to send for and examine witnesses, papers and records, and to extend to any witness the protection of the House; and

(d) The select committee be empowered to meet outside the province touching on matters pertaining to its study, review and recommendations; and

(e) All the powers and privileges under the House of Assembly Act and amendments thereto and the Rules of the House applicable to Standing and Select Committees while the House is in session shall apply and be of full force and effect during the sittings of the select committee; and

(f) This House do authorize the Legislature Internal Economy Board, on behalf of the select committee, to employ such members and staff as may be necessary to enable the select committee to carry out its duties; and

(g)This House declare that the Legislature Internal Economy Board be authorized to provide the select committee, its members and staff with such facilities and funds as are required to carry out their duties and as are provided for by and pursuant to Section 50 of the Public Service Act.

Mr. Speaker: The notice is tabled.

The honourable Minister of Development.

Hon. Roland Thornhill: Mr. Speaker, it reminds me of last night, trying to kill time till the Minister of Agriculture gets back.

Mr. Vincent MacLean: To provide a solution to some of the social and economic problems of Cape Breton County, Mr. Speaker. (Applause)

Mr. Speaker: Thank you, very much. I can now follow it. Order, please. That will be the subject for debate at 6:00 o'clock.

Government Business

Mr. Speaker: The honourable Minister of Development.

Hon. Roland Thornhill: Mr. Speaker, would you please call the order of business, Government Motions.

Government Motions

Resolution No. 192, Health Care, Select Committee — notice given April 6/82 — (Hon. R. Thornhill)

Mr. Speaker: The honourable Minister of Development.

Hon. Roland Thornhill: Mr. Speaker, I would so move.

Mr. Speaker: Is the House ready for the question? The question is on the motion to establish a Select Committee to Inquire into Health Care in the Province. Those in favour will please say Aye. Contrary minded, Nay.

The motion is carried.

The honourable Minister of Development.

Hon. Roland Thornhill: Mr. Speaker, as Chairman of the Striking Committee I would like to announce the members of that particular committee. The chairman will be Dr. Colin Stewart, the members are Hon. Gerald Sheehy, Hon. Edmund Morris, Hon. Laird Stirling, Mr. Greg MacIsaac, Mr. John Leefe, Ms. Alexa McDonough, Mr. Sandy Cameron, Mr. Vincent MacLean, Mr. Fraser Mooney and Mr. Bill Gillis. The honourable Speaker will be an ex-officio member, as always, of this select committee.

Resolution No. 222

Hon. Roland Thornhill: Mr. Speaker, I hereby give notice that on a future day I shall move a resolution in the form of the attached hereto.

(Whereas this House did at the First Session of the Fifty-Third General Assembly establish certain Special or Select Committees, namely:

(a) a Select Committee to inquire into Tourism;

(b) a Select Committee to inquire into Volunteer Fire Departments and Volunteer Firemen;

(c) a Select Committee to inquire into the adequacy and delivery of health care in the Province;

(d) a Select Committee to review the E.M.O. (N.S.) Act and regulations;

(e) a Select Committee relating to the development of the offshore region; and

(f) a Special Committee to study the Rules and Forms of Procedure of the House of Assembly; and

Whereas the said Committees did during the said First Session which expired on the Twenty-fourth day of February, A.D., 1983, meet as directed by the Resolutions of this House pertaining to them; and

Whereas the said Committees pursuant to Section 37A of the House of Assembly Act were not declared not to be dissolved by prorogation of this House; and

Whereas subsection (3) of said Section 37A declares that this House at the next Session following such Resolutions shall appoint new Committees consisting of the same or other members to inquire into the same matters as the Committees that were authorized to continue their inquiries under subsection (1) of said Section 37A and that the said Committees are thereupon dissolved and that they shall deliver to the new Committees all material considered, evidence taken by them and their findings thereon, if any; and

Whereas the new Committees may consider all of the material, evidence and findings delivered to them pursuant to subsection (3) of said Section 37A and may continue to inquire into the matters into which the original Committees were authorized to inquire;

Now therefore I move that the

(a) Select Committee to inquire into Tourism;

(b) Select Committee to inquire into Volunteer Fire Departments and Volunteer Firemen;

(c) Select Committee to inquire into the adequacy and delivery of health care in the Province;

(d) Select Committee to review the E.M.O. (N.S.) Act and regulations; and

(e) Select Committee relating to the development of the offshore region; and

(f) Special Committee to study the Rules and Forms of Procedure of the House of Assembly;

be re-established consisting of the same or such other members as the Striking Committee may determine:

(1) to inquire into the same matters as those Committees were authorized by the First Session of the Fifty-third Assembly to inquire into;

(2) the original Committees deliver to the new Committees all material considered and evidence taken by them and their findings thereon, if any;

(3) the new Committees consider all material, evidence and findings delivered to them and continue to inquire into the matters that were referred to the appropriate original Committee by this House at the First Session of the Fifty-third General Assembly;

(4) the said Committees have and may exercise the same powers conferred upon the appropriate original Committee by the said First Session of the Fifty-third General Assembly; and

(5) the said Committees are not dissolved by prorogation of this House and are authorized to continue their inquires after the House has prorogued.)

Resolution No. 112

Hon. Roland Thornhill: Mr. Speaker, I hereby give notive that on a future day I shall move a resolution in the form of the attached hereto:

Whereas this House did at the second session of the Fifty-third General Assembly re-establish certain special or select committees, namely a Select Committee to inquire into Tourism, a Select Committee to inquire into Volunteer Fire Departments and Volunteer Firemen, a Select Committee to inquire into the adequacy and delivery of Health Care in the province, a Select Committee to review the EMO (N.S.) Act and Regulations, a Select Committee relating to the Development of Offshore Region and a Special Committee to study the Rules and Forms of Procedures of the House of Assembly; and

Whereas the said committees did during the said second session which expired on the 27th day of February, 1984, meet as directed by the resolutions of this House pertaining to them; and

Whereas the said committees pursuant to Section 37A of the House of Assembly Act were declared not to be dissolved by the prorogation of this House; and

Whereas subsection (3) of the said Section 37A declares that this House at the next session, following such resolutions shall appoint new committees consisting of the same or other members to inquire into the same matters as the committees that were authorized to continue their inquiries under subsection (1) of said Section 37A and, that the said committees are thereupon dissolved and that they shall deliver to the new committees all material considered evidence taken by them and their findings thereon if any; and

Whereas the new committees may consider all of the material evidence in findings delivered to them pursuant to subsection (3) of the said Section 37A and may continue to inquire into the matters into which the committees were originally authorized to inquire;

Therefore, Mr. Speaker, I move that the Select Committee to inquire into Tourism, the Select Committee to inquire into Volunteer Fire Departments and Volunteer Firemen, the Select Committee to inquire into the adequacy and delivery of Health Care in the province, the Select Committee to review the EMO (N.S.) Act and Regulations and the Select Committee relating to the Development of the Offshore Region and Special Committee to study the Rules and Forms of Procedure of the House of Assembly be re-established consisting of the same or such other members as the striking committee may determine:

(1) to inquire into the same matters as those committees were authorized by the 53rd General Assembly;

(2) the committees deliver to the new committees all material considered and evidence taken by them and their findings thereon;

(3) the new committees consider all material, evidence and findings delivered to them and continue to inquire into the matters that were referred to the appropriate committee by this General Assembly;

(4) the said committees have and may exercise the same powers conferred upon the appropriate committee by this General Assembly and the said committees are not dissolved by prorogation of this House and are authorized to continue their inquiries after the House has prorogued.

Mr. Speaker: The notice is tabled.

Government Motions

Mr. Speaker: The honourable Minister of Development.

Hon. Roland Thornhill: Mr. Speaker, would you please call Resolution No. 112.

Res. No. 112, re Select Committees (Tourism, Volunteer Fire Depts., Health, EMO, Offshore, Rules of the House) — Re-establish — notice given Mar. 20/84 — (Hon. R. Thornhill)

Mr. Speaker: The honourable Minister of Development.

Hon. Roland Thornhill: Mr. Speaker, I would so move.

Mr. Speaker: Is the House ready for the question? Perhaps there could be a reading of the operative part of the resolution.

(The resolution was read by the Clerk.)

Mr. Speaker: Is the House ready for the question? The motion is for passage of Resolution No. 112. Would all those in favour of the motion please say Aye. Contrary minded, Nay.

The motion is carried.

Appendix III

Places and Dates of Public Hearings:
Select Committee on Health

November 23, 1982 - Halifax
November 24, 1982 - Halifax
November 30, 1982 - Halifax
January 31, 1983 - Sydney
February 9, 1983 - Halifax
February 16, 1983 - Halifax
February 23, 1983 - Halifax
March 9, 1983 - Halifax
April 6, 1983 - Halifax
July 18, 1983 - Halifax
July 19, 1983 - Halifax
July 20, 1983 - Halifax
September 19, 1983 - Yarmouth
September 20, 1983 - Kentville
October 24, 1983 - Sydney
October 25, 1983 - Sydney
November 14, 1983 - Antigonish
November 15, 1983 - Truro
November 16, 1983 - Halifax